
**IN THE UNITED STATES DISTRICT COURT
DISTRICT OF UTAH, CENTRAL DIVISION**

IHC HEALTH SERVICES, INC. d/b/a
INTERMOUNTAIN MEDICAL CENTER,

Plaintiff,

v.

BLUE CROSS BLUE SHIELD OF TEXAS and
SERVICE EXPERTS HEATING & AIR
CONDITIONING LLC,

Defendants.

**DECLARATION OF VIRGINIA D.
VENABLE IN SUPPORT OF
DEFENDANTS' CONSOLIDATED
MOTION TO DISMISS
PLAINTIFFS' COMPLAINTS**

Case No. 2:17-CV-00216-RJS-BCW

Judge Robert J. Shelby
Magistrate Judge Brooke C. Wells

Also Filed in Case Nos.

2:17-CV-00503-RJS

2:17-CV-00514-RJS-DBP

2:17-CV-00733-RJS-BCW

2:17-CV-00867-RJS-PMW

2:17-CV-00906-RJS

2:17-CV-00994-RJS

2:17-CV-01271-PMW

2:17-CV-01320-RJS

2:18-CV-00053-RJS

I, Virginia D. Venable, hereby declare as follows:

1. I am Divisional Vice President, Sales Delivery Group at Health Care Service Corporation ("HCSC"), a mutual legal reserve company of which Blue Cross and Blue Shield of Illinois ("BCBSIL") and Blue Cross and Blue Shield of Texas ("BCBSTX") are unincorporated divisions. I have knowledge of the matters stated in this declaration, and I could and would testify competently thereto if called to do so.

2. As Divisional Vice President, Sales Delivery Group at HCSC, my responsibilities include overseeing HCSC's Contract Administration department, which is responsible for drafting and maintaining various member benefit plan materials.

3. Attached hereto as **Exhibit A** is a true and correct copy of the benefit booklet and summary plan description that HCSC has in its files for the Service Experts LLC HD Premium Option Plan, which is the benefit plan in which E.C., the patient identified in the *Service Experts* Complaint, was enrolled on March 23, 2014. *See* Second Amended Complaint ¶¶ 4, 11, 15, Case No. 2:17-CV-00216-RJS-BCW (Dkt. No. 49).

4. Attached hereto as **Exhibit B** is a true and correct copy of the benefit booklet and summary plan description that HCSC has in its files for the Patterson-UTI Energy, Inc. Managed Health Care (PPO) and Pharmacy Benefits Plan, which is the benefit plan in which H.H., the patient identified in the *Patterson* Complaint, was enrolled from May 29, 2014, through June 3, 2014. *See* First Amended Complaint ¶¶ 4, 9, 12, Case No. 2:17-CV-00503-RJS (Dkt. No. 31).

5. Attached hereto as **Exhibit C** is a true and correct copy of the administrative facts section of the summary plan description that HCSC has in its files for the Schneider Electric Benefit Program for U.S. Employees, which is the benefit plan in which A.C., the patient identified in the *Schneider* Complaint, was enrolled from June 28, 2014, through July 2, 2014. *See* Complaint ¶¶ 4, 9, 12, Case No. 2:17-CV-00733-RJS-BCW (Dkt. No. 2).

6. Attached hereto as **Exhibit D** is a true and correct copy of the benefit booklet that HCSC has in its files for the Accenture LLP Enhanced PPO Plan, which is the benefit plan in which R.S., the patient identified in the *Schneider* Complaint, was enrolled from July 30, 2014,

through August 2, 2014. *See* Complaint ¶¶ 4, 11, 14, Case No. 2:17-CV-00867-RJS-PMW (Dkt. No. 2).

7. Attached hereto as **Exhibit E** is a true and correct copy of the benefit booklet and summary plan description that HCSC has in its files for the BRG Sports, Inc. Premier Plan, which is the benefit plan in which S.B., the patient identified in the *Riddell* Complaint, was enrolled on September 3, 2014. *See* Complaint ¶¶ 4, 9, 13, Case No. 2:17-CV-00994-RJS (Dkt. No. 2).

8. Attached hereto as **Exhibit F** is a true and correct copy of the benefit booklet that HCSC has in its files for the YRC Worldwide Hourly Plan, which is the benefit plan in which T.F., the patient identified in the *YRC* Complaint, was enrolled from November 21, 2014, through December 10, 2014. *See* Complaint ¶¶ 4, 9, 13, Case No. 2:17-CV-01271-PMW (Dkt. No. 2).

9. Attached hereto as **Exhibit G** is a true and correct copy of the summary plan description that HCSC has in its files for the Illinois Tool Works Medical Plan, which is the benefit plan in which T.L., the patient identified in the *ITW* Complaint, was enrolled from January 15, 2015, through January 18, 2015. *See* Complaint ¶¶ 4, 10, 15, Dkt. No. 2:18-CV-00053-RJS (Dkt. No. 2).

10. Attached hereto as **Exhibit H** is a true and correct copy of the Certificate of Health Care Benefits for the Blue PPO Gold 016 PPO Plan that HCSC has in its files, and which is the benefit plan in which C.W., the patient identified in the *NWRA* Complaint, was enrolled from July 27, 2014, through August 9, 2014. *See* Complaint ¶¶ 2, 5, 8, Case No. 2:17-CV-00906-RJS (Dkt. No. 2).

11. Attached hereto as **Exhibit I** is a true and correct copy of the Discover Financial Services Welfare Benefits Plan that HCSC has in its files, which is the benefit plan in which D.S., the patient identified in the *DFS* Complaint, was enrolled from December 16, 2014, through December 26, 2014. *See* Complaint ¶¶ 4, 9, 13, Case No. 2:17-CV-01320-RJS (Dkt. No. 2).

12. Attached hereto as **Exhibit K** is a true and correct copy of the benefit booklet and summary plan description that HCSC has in its files for the BRG Sports, Inc. Premier Plan, which is the benefit plan in which R.G., the patient identified in the *Easton* Complaint, was enrolled from May 14, 2014, through June 5, 2014. *See* First Amended Complaint ¶¶ 5, 10, 13, Case No. 2:17-CV-00514-RJS-DBP (Dkt. No. 19).

13. Attached hereto as **Exhibit U** is a true and correct copy of the summary plan description that HCSC has in its files for the Discover Welfare Benefits Plan, which is the benefit plan in which D.S., the patient identified in the *DFS* Complaint, was enrolled from December 16, 2014, through December 26, 2014. *See* Complaint ¶¶ 4, 9, 13, Case No. 2:17-CV-01320-RJS (Dkt. No. 2).

14. HCSC, through its unincorporated divisions BCBSIL and BCBSTX, did not consent to any of the alleged assignments of benefits by the patients identified in the above-referenced actions to IHC Health Services, Inc. or any of its hospitals.

Pursuant to 28 U.S.C. § 1746, I certify under penalty of perjury that the foregoing is true and correct.



Virginia D. Venable

Executed in Chicago, Illinois, this 20th day of February, 2018.

EXHIBIT A

Your Health Care Benefits Program



Service Experts LLC

Account #121225

Group #121226

Office Visit services subject to Co-Share and Deductible

HD Premium Option Plan

Managed Health Care

Administered by:



BlueCross BlueShield of Texas



January 1, 2014

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SCHEDULE OF COVERAGE HD PREMIUM OPTION PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles* <ul style="list-style-type: none"> Calendar Year Deductible <i>Applies to all Eligible Expenses</i> 	\$1,250 – per individual \$2,500 – per family	\$2,500 – per individual \$5,000 – per family
Out-of-Pocket Maximum* <i>Includes Calendar Year Deductible</i>	\$4,500 – per individual \$9,000 – per family	\$9,000 – per individual \$18,000 – per family
Inpatient Hospital Expenses (Preauthorization is required) All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	80% of Allowable Amount after Calendar Year Deductible No penalty for failure to preauthorize services	60% of Allowable Amount after Calendar Year Deductible 20% penalty for failure to preauthorize services
Medical-Surgical Expenses <ul style="list-style-type: none"> Office visit/consultation including lab and x-rays Inpatient visits and Certain Diagnostic Procedures Home Infusion Therapy (Preauthorization is required) Physician surgical services in any setting Independent Lab & X-ray Allergy Injections (without office visit) Early Detection Tests for Cardiovascular Disease 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Extended Care Expenses (Preauthorization is required)	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> Skilled Nursing Facility Home Health Care Hospice Care 	60 days maximum per Calendar Year 60 visits maximum per Calendar Year Unlimited	

* The Deductibles and Out-of-Pocket Maximum apply for prescription drug benefits administered by Express Scripts.

SCHEDULE OF COVERAGE HD PREMIUM OPTION PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Mental Health Care/Serious Mental Illness/Treatment of Chemical Dependency (Certain Services will require Preauthorization) Inpatient Services <ul style="list-style-type: none"> Hospital Services (facility) Behavioral Health Practitioner Services Outpatient Services <ul style="list-style-type: none"> Behavioral Health Practitioner Expenses (office setting) Other Outpatient Services 	80% of Allowable Amount after Calendar Year Deductible 80% of Allowable Amount after Calendar Year Deductible 80% of Allowable Amount after Calendar Year Deductible 80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible
Emergency Care Accidental Injury & Emergency Care (including Accidental Injury & Emergency Care for Behavioral Health Services) <ul style="list-style-type: none"> Facility Charges Physician Charges 	80% of Allowable Amount after Calendar Year Deductible 80% of Allowable Amount after Calendar Year Deductible	
Non-Emergency Care (including Accidental Injury & Emergency Care for Behavioral Health Services) <ul style="list-style-type: none"> Facility Charges Physician Charges 	80% of Allowable Amount after Calendar Year Deductible 80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible
Urgent Care Services <ul style="list-style-type: none"> Urgent Care Center visit – including Lab & x-ray services (excluding Certain Diagnostic Procedures) 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Ambulance Services	80% of Allowable Amount after Calendar Year Deductible	

**SCHEDULE OF COVERAGE
HD PREMIUM OPTION PLAN**

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Preventive Care Services		
<ul style="list-style-type: none"> Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") 	100% of Allowable Amount	Not Covered
<ul style="list-style-type: none"> Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved 	100% of Allowable Amount	Not Covered
<ul style="list-style-type: none"> Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents 	100% of Allowable Amount	Not Covered
<ul style="list-style-type: none"> With respect to women, such additional preventive care and screenings, not described in the first bullet above, as provided for in comprehensive guidelines supported by the HRSA 	100% of Allowable Amount	Not Covered
<ul style="list-style-type: none"> Routine physical examinations, well baby care, immunizations and routine lab 	100% of Allowable Amount	Not Covered
<ul style="list-style-type: none"> Colonoscopy Professional (physician charges) 	100% of Allowable Amount	Not Covered
<ul style="list-style-type: none"> Colonoscopy facility charges 	100% of Allowable Amount	Not Covered
<ul style="list-style-type: none"> Healthy diet counseling and obesity screening/counseling 	100% of Allowable Amount	Not Covered
Other Routine Services		
<ul style="list-style-type: none"> X-Ray 	100% of Allowable Amount	Not Covered
<ul style="list-style-type: none"> Annual Hearing Examination 	100% of Allowable Amount	Not Covered
<ul style="list-style-type: none"> Annual Vision Examination 	100% of Allowable Amount	Not Covered
Speech and Hearing Services, excluding hearing aids	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Chiropractic Services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Physical Medicine Services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE

Dependent Eligibility

Dependent Child Age Limit to age 26.

Dependent children are eligible for Maternity Care benefits.

Preexisting Conditions

Preexisting Conditions are covered immediately.

INTRODUCTION

This Plan is offered by your Employer as one of the benefits of your employment. The benefits provided are intended to assist you with many of your health care expenses for Medically Necessary services and supplies. Coverage under this Plan is provided regardless of your race, color, national origin, disability, age, sex, gender identity or sexual orientation. There are provisions throughout this Benefit Booklet that affect your health care coverage. It is important that you read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan. In the event of any conflict between any components of this Plan, the Administrative Services Agreement provided to your Employer by Blue Cross and Blue Shield of Texas (BCBSTX) prevails.

The defined terms in this Benefit Booklet are capitalized and shown in the appropriate provision in the Benefit Booklet or in the **DEFINITIONS** section of the Benefit Booklet. Whenever these terms are used, the meaning is consistent with the definition given. Terms in italics may be section headings describing provisions or they may be defined terms.

The terms “you” and “your” as used in this Benefit Booklet refer to the Employee. Use of the masculine pronoun “his,” “he,” or “him” will be considered to include the feminine unless the context clearly indicates otherwise.

Managed Health Care – In–Network Benefits

To receive In–Network Benefits as indicated on your Schedule of Coverage, **you must** choose Providers within the Network for all care (**other than for emergencies**). The Network has been established by BCBSTX and consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Participants throughout the Network Plan Service Area. Refer to your Provider directory or visit the BCBSTX website at www.bcbstx.com to make your selections. The listing may change occasionally, so make sure the Providers you select are still Network Providers. An updated directory will be available at least annually. You may access our website, www.bcbstx.com, for the most current listing to assist you in locating a Provider.

To receive In–Network Benefits for Mental Health Care, Serious Mental Illness, and treatment of Chemical Dependency all inpatient and certain outpatient care should be Preauthorized by calling the toll-free Mental Health Helpline indicated on your Identification Card and in this Benefit Booklet. Services and supplies for Mental Health Care, Serious Mental Illness, and treatment of Chemical Dependency must be provided by Network Providers that have specifically contracted with the Claim Administrator to furnish services and supplies for those types of conditions to be considered for In–Network Benefits.

If you choose a Network Provider, the Provider will bill the Claim Administrator – not you – for services provided.

The Provider has agreed to accept as payment in full the least of...

- The billed charges, or
- The Allowable Amount as determined by the Claim Administrator, or
- Other contractually determined payment amounts.

You are responsible for paying any Deductibles and Co–Share Amounts. The Deductibles and Co–Share will be applied to the Out–of–Pocket Maximum. You may be required to pay for limited or non–covered services. No claim forms are required.

Managed Health Care – Out–of–Network Benefits

If you choose Out–of–Network Providers, only Out–of–Network Benefits will be available. If you go to a Provider outside the Network, benefits will be paid at the Out–of–Network Benefits level. If you choose a health care Provider outside the Network, you may have to submit claims for the services provided.

You will be responsible for paying...

- Billed charges above the Allowable Amount as determined by the Claim Administrator,
- Co-Share Amounts and Deductibles, which will be applied to the Out-of-Pocket Maximum,
- Limited or non-covered services, and
- Failure to Preauthorize penalty.

Important Contact Information

Resource	Contact Information	Accessible Hours
Customer Service Helpline	1-800-521-2227	Monday – Friday 8:00 a.m. – 8:00 p.m.
Website	www.bcbstx.com	24 hours a day 7 days a week
Medical Preauthorization Helpline	1-800-441-9188	Monday – Friday 7:30 a.m. – 6:00 p.m.
Mental Health/Chemical Dependency Preauthorization Helpline	1-800-528-7264	24 hours a day 7 days a week

Customer Service Helpline

Customer Service Representatives can:

- Identify your Plan Service Area
- Give you information about Network and *ParPlan* Providers
- Distribute claim forms
- Answer your questions on claims
- Assist you in identifying a Network Provider (but will not recommend specific Network Providers)
- Provide information on the features of the Plan
- Record comments about Providers

BCBSTX Website

Visit the BCBSTX website at www.bcbstx.com for information about BCBSTX, access to forms referenced in this Benefit Booklet, and much more.

Mental Health/Chemical Dependency Preauthorization Helpline

To satisfy Preauthorization requirements for Participants seeking treatment for Behavioral Health Services, Mental Health Care, Serious Mental Illness, and Chemical Dependency, you, your Behavioral Health Practitioner, or a family member may call the Mental Health/Chemical Dependency Preauthorization Helpline at any time, day or night.

Medical Preauthorization Helpline

To satisfy all medical Preauthorization requirements for inpatient Hospital Admissions, Extended Care Expenses, or Home Infusion Therapy, call the Medical Preauthorization Helpline.

WHO GETS BENEFITS

Eligibility Requirements for Coverage

The Eligibility Date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when he becomes an Employee or a Dependent and is in a class eligible to be covered under the Plan. The Eligibility Date is:

1. The date the Employee, including any Dependents to be covered, completes the Waiting Period, if any, for coverage;
2. Described in the ***Dependent Enrollment Period*** section for a new Dependent of an Employee already having coverage under the Plan.

No eligibility rules or variations in rates will be imposed based on your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of your race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

Employee Eligibility

Any person eligible under this Plan and covered by the Employer's previous Health Benefit Plan on the date prior to the Plan Effective Date, including any person who has continued group coverage under applicable federal or state law, is eligible on the Plan Effective Date. Otherwise, you are eligible for coverage under the Plan when you satisfy the definition of an Employee and you reside or work in the Plan Service Area.

Dependent Eligibility

If you apply for coverage, you may include your Dependents. Eligible Dependents are:

1. Your spouse or your Domestic Partner;
2. A child under the limiting age shown in your Schedule of Coverage;
3. A child of your child who is your Dependent for federal income tax purposes at the time application for coverage of the child is made;
4. Any other child included as an eligible Dependent under the Plan.

A detailed description of Dependent is in the **DEFINITIONS** section of this Benefit Booklet. An Employee must be covered first in order to cover his eligible Dependents. No Dependent shall be covered hereunder prior to the Employee's Effective Date. If you are married to another Employee or have a Domestic Partner who is an Employee, you may not cover your spouse or Domestic Partner as a Dependent, and only one of you may cover any Dependent children.

Effective Dates of Coverage

In order for an Employee's coverage to take effect, the Employee must submit written enrollment for coverage for himself and any Dependents. The Effective Date is the date the coverage for a Participant actually begins. The Effective Date under the Plan is shown on your Identification Card. It may be different from the Eligibility Date.

Timely Applications

It is important that your application for coverage under the Plan is received timely by the Claim Administrator through the Plan Administrator.

If you apply for coverage and make the required contributions for yourself or for yourself and your eligible Dependents and if you:

1. Are eligible on the Plan Effective Date and the application is received by the Claim Administrator through the Plan Administrator prior to or within 31 days following such date, your coverage will become effective on the Plan Effective Date;
2. Enroll for coverage for yourself or for yourself and your Dependents during an Open Enrollment Period, coverage shall become effective on the Plan Anniversary Date; or
3. Become eligible after the Plan Effective Date and if the application is received by the Claim Administrator through the Plan Administrator within the first 31 days following your Eligibility Date, the coverage will become effective in accordance with eligibility information provided by your Employer.

Effective Dates - Delay of Benefits Provided

Coverage becomes effective for you and/or your Dependents on the Plan Effective Date upon completion of an application for coverage. If you or your eligible Dependent(s) are confined in a Hospital or Facility Other Provider on the Plan Effective Date, your coverage is effective on the Plan Effective Date. However, if this Plan is replacing a discontinued Health Benefit Plan or self-funded Health Benefit Plan, benefits for any Employee or Dependent may be delayed until the expiration of any applicable extension of benefits provided by the previous Health Benefit Plan or self-funded Health Benefit Plan.

Effective Dates - Late Enrollee

If your application is not received within 31 days from the Eligibility Date, you will be considered a Late Enrollee. You will become eligible to apply for coverage during your Employer's next Open Enrollment Period. Your coverage will become effective on the Plan Anniversary Date.

Loss of Other Health Insurance Coverage

An Employee who is eligible, but not enrolled for coverage under the terms of the Plan (and/or a Dependent, if the Dependent is eligible, but not enrolled for coverage under such terms) shall become eligible to apply for coverage if each of the following conditions is met:

1. The Employee or Dependent was covered under a Health Benefit Plan, self-funded Health Benefit Plan, or had other health insurance coverage at the time this coverage was previously offered; and
2. Coverage was declined under this Plan in writing, on the basis of coverage under another Health Benefit Plan or self-funded Health Benefit Plan; and
3. There is a loss of coverage under such prior Health Benefit Plan or self-funded Health Benefit Plan as a result of:
 - a. Exhaustion of continuation under Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended; or
 - b. Cessation of Dependent status (such as divorce or attaining the maximum age to be eligible as a dependent child under the Plan), termination of employment, a reduction in the number of hours of employment, or employer contributions toward such coverage were terminated; or
 - c. Termination of the other plan's coverage, a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits, a situation in which the other plan no longer offers any benefits to the class of similarly situated individuals that include you or your Dependent, or, in the case of coverage offered through an HMO, you or your Dependent no longer reside, live, or work in the service area of that HMO and no other benefit option is available; and
4. You request to enroll no later than 31 days after the date coverage ends under the prior Health Benefit Plan or self-funded Health Benefit Plan or, in the event of the attainment of a lifetime limit on all benefits, the request to enroll is made not later than 31 days after a claim is denied due to the attainment of a lifetime limit on all benefits. Coverage will become effective the first day of the Plan Month following receipt of the application by the Claim Administrator through the Plan Administrator.

If all conditions described above are not met, you will be considered a Late Enrollee.

Loss of Governmental Coverage

An individual who is eligible to enroll and who has lost coverage under Medicaid (Title XIX of the Social Security Act), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s) or

under the Children's Health Insurance Program (CHIP), Chapter 62, Health and Safety Code, is not a Late Enrollee provided appropriate enrollment application/change forms and applicable contributions are received by the Claim Administrator within sixty (60) days after the date on which such individual loses coverage. Coverage will be effective the day after prior coverage terminated.

Health Insurance Premium Payment (HIPP) Reimbursement Program

An individual who is eligible to enroll and who is a recipient of medical assistance under the Medicaid Program or enrolled in CHIP, and who is a participant in the HIPP Reimbursement Program may enroll with no enrollment period restrictions. If the individual is not eligible unless a family member is enrolled, both the individual and family member may enroll. The Effective Date of Coverage is on the first day of the month after the Claim Administrator receives (i) written notice from the Texas Health and Human Services Commission, or (ii) enrollment forms, from you, provided such forms and applicable contributions are received by the Claim Administrator within sixty (60) days after the date the individual becomes eligible for participation in the HIPP Reimbursement Program.

Dependent Enrollment Period

1. Special Enrollment Period for Newborn Children

Coverage of a newborn child will be automatic for the first 31 days following the birth of your newborn child. For coverage to continue beyond this time, you must notify the Claim Administrator through the Plan Administrator within 31 days of birth and pay any required contributions within that 31-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of birth. If the Claim Administrator is notified through the Plan Administrator after that 31-day period, the newborn child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period.

2. Special Enrollment Period for Adopted Children or Children Involved in a Suit for Adoption

Coverage of an adopted child or child involved in a suit for adoption will be automatic for the first 31 days following the adoption or date on which a suit for adoption is sought. For coverage to continue beyond this time, the Claim Administrator through the Plan Administrator must receive all necessary forms and the required contributions within the 31-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of adoption or date on which a suit for adoption is sought. If you notify the Claim Administrator through the Plan Administrator after that 31-day period, the child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period.

3. Court Ordered Dependent Children

If a court has ordered an Employee to provide coverage for a child, coverage will be automatic for the first 31 days after the date your Employer receives notification of the court order. To continue coverage beyond the 31 days, the Claim Administrator through the Plan Administrator must receive all necessary forms and the required contributions within the 31-day period. If you notify the Claim Administrator through the Plan Administrator after that 31-day period, the Dependent child's coverage will become effective on the Plan Anniversary Date following your Employer's next Open Enrollment Period.

4. Other Dependents

Written application must be received within 31 days of the date that a spouse or Domestic Partner or child first qualifies as a Dependent. If the written application is received within 31 days, coverage will become effective on the date the child or spouse or Domestic Partner first becomes an eligible Dependent. If application is not made within the initial 31 days, then your Dependent's coverage will become effective on the Plan Anniversary Date following your Employer's next Open Enrollment Period.

If you ask that your Dependent be provided health care coverage after having canceled his or her coverage while your Dependent was still entitled to coverage, your Dependent's coverage will become effective in accordance with the provisions of the Plan.

In no event will your Dependent's coverage become effective prior to your Effective Date.

Other Employee Enrollment Period

1. As a special enrollment period event, if you acquire a Dependent through birth, adoption, or through suit for adoption, and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance***

Coverage, as described above, you may apply for coverage for yourself, your spouse or Domestic Partner, and a newborn child, adopted child, or child involved in a suit for adoption. If the written application is received within 31 days of the birth, adoption, or suit for adoption, coverage for the child, you, or your spouse or Domestic Partner will become effective on the date of the birth, adoption, or date suit for adoption is sought.

If you marry or enter into a Domestic Partnership and you previously declined coverage for reasons other than under **Loss of Other Health Insurance Coverage** as described above, you may apply for coverage for yourself and your spouse or Domestic Partner. If the written application is received within 31 days of the marriage or establishment of a Domestic Partnership, coverage for you and your spouse or Domestic Partner will become effective on the first day of the month following receipt of the application by the Claim Administrator through the Plan Administrator.

2. If you are required to provide coverage for a child as described in **Court Ordered Dependent Children** above, and you previously declined coverage for reasons other than under **Loss of Other Health Insurance Coverage**, you may apply for coverage for yourself. If the written application is received within 31 days of the date your Employer receives notification of the court order, coverage for you will become effective on the date your Employer receives notification of the court order.

Group Enrollment Application/Change Form

Use this form to...

- Notify the Plan of a change to your name
- Add Dependents
- Drop Dependents
- Cancel all or a portion of your coverage
- Notify the Plan of all changes in address for yourself and your Dependents. An address change may result in benefit changes for you and your Dependents if you move out of the Plan Service Area of the Network.

You may obtain this form from your Employer, or by calling the Claim Administrator's Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card, or by accessing the BCBSTX website. If a Dependent's address and zip code are different from yours, be sure to indicate this information on the form. After you have completed the form, return it to your Employer.

Changes In Your Family

You should promptly notify the Claim Administrator through the Plan Administrator in the event of a birth or follow the instructions below when events, such as but not limited to, the following take place:

- If you are adding a Dependent due to marriage or establishment of a Domestic Partnership, adoption, or a child being involved in a suit for which an adoption of the child is sought, or your Employer receives a court order to provide health coverage for a Participant's child or your spouse, you must submit a **Group Enrollment Application/Change Form** and the coverage of the Dependent will become effective as described in **Dependent Enrollment Period**.
- When you divorce or terminate a Domestic Partnership or your child reaches the age indicated on your Schedule of Coverage as "Dependent Child Age Limit," or a Participant in your family dies, coverage under the Plan terminates in accordance with the **Termination of Coverage** provisions selected by your Employer.

Notify your Employer promptly if any of these events occur. Benefits for expenses incurred after termination are not available. If your Dependent's coverage is terminated, refund of contributions will not be made for any period before the date of notification. If benefits are paid prior to notification to the Claim Administrator by the Plan Administrator, refunds will be requested.

Please refer to the **Continuation of Group Coverage – Federal** subsection in this Benefit Booklet for additional information.

HOW THE PLAN WORKS

Allowable Amount

The Allowable Amount is the maximum amount of benefits the Claim Administrator will pay for Eligible Expenses you incur under the Plan. The Claim Administrator has established an Allowable Amount for Medically Necessary services, supplies, and procedures provided by Providers that have contracted with the Claim Administrator or any other Blue Cross and/or Blue Shield Plan, and Providers that have not contracted with the Claim Administrator or any other Blue Cross and/or Blue Shield Plan. When you choose to receive services, supplies, or care from a Provider that does not contract with the Claim Administrator, you will be responsible for any difference between the Claim Administrator's Allowable Amount and the amount charged by the non-contracting Provider. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan, any applicable Deductibles and Co-Share amounts.

Review the definition of Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet to understand the guidelines used by the Claim Administrator.

Case Management

Under certain circumstances, the Plan allows the Claim Administrator the flexibility to offer benefits for expenses which are not otherwise Eligible Expenses. The Claim Administrator, at its sole discretion, may offer such benefits if:

- The Participant, his family, and the Physician agree;
- Benefits are cost effective; and
- The Claim Administrator anticipates future expenditures for Eligible Expenses which may be reduced by such benefits.

Any decision by the Claim Administrator to provide such benefits shall be made on a case-by-case basis. The case coordinator for the Claim Administrator will initiate case management in appropriate situations.

Freedom of Choice

<i>Each time you need medical care, you can choose to:</i>		
See a Network Provider	See an Out-of-Network Provider	
	ParPlan Provider (refer to ParPlan, below, for more information)	Out-of-Network Provider (not a contracting Provider)
<ul style="list-style-type: none"> • You receive the higher level of benefits (In-Network Benefits) • You are not required to file claim forms • You are not balance billed; Network Providers will not bill for costs exceeding the Claim Administrator's Allowable Amount for covered services • Your Provider will Preauthorize necessary services 	<ul style="list-style-type: none"> • You receive the lower level of benefits (Out-of-Network Benefits) • You are not required to file claim forms in most cases; <i>ParPlan</i> Providers will usually file claims for you • You are not balance billed; <i>ParPlan</i> Providers will not bill for costs exceeding the Claim Administrator's Allowable Amount for covered services • In most cases, <i>ParPlan</i> Providers will Preauthorize necessary services 	<ul style="list-style-type: none"> • You receive Out-of-Network Benefits (the lower level of benefits) • You are required to file your own claim forms • You may be billed for charges exceeding the Claim Administrator's Allowable Amount for covered services • You must Preauthorize necessary services

Identification Card

The Identification Card tells Providers that you are entitled to benefits under your Employer's Health Benefit Plan. The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

- ***Your Subscriber identification number.*** This unique identification number is preceded by a three character alpha prefix that identifies Blue Cross and Blue Shield of Texas as your Claim Administrator.
- ***Your group number.*** This is the number assigned to identify your Employer's Health Benefit Plan with the Claim Administrator.
- ***Important telephone numbers.***

Always remember to carry your Identification Card with you and present it to your Providers when receiving health care services or supplies.

Please remember that any time a change in your family takes place it may be necessary for a new Identification Card to be issued to you (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, the Claim Administrator will provide a new Identification Card.

Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards

1. The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you and your covered Dependents will include, but not be limited to, the following actions, when intentional:
 - a. Use of the Identification Card prior to your Effective Date;
 - b. Use of the Identification Card after your date of termination of coverage under the Plan;
 - c. Obtaining other benefits for persons not covered under the Plan;
 - d. Obtaining other benefits that are not covered under the Plan.
2. The fraudulent or intentionally unauthorized, abusive, or other improper use of Identification Cards by any Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under your coverage:
 - a. Denial of benefits;
 - b. Cancellation of coverage under the Plan for **all** Participants under your coverage;
 - c. Limitation on the use of the Identification Card to one designated Physician, Other Provider of your choice;
 - d. Recoupment from you or any of your covered Dependents of any benefit payments made;
 - e. Pre-approval of medical services for all Participants receiving benefits under your coverage;
 - f. Notice to proper authorities of potential violations of law or professional ethics.

Medical Necessity

All services and supplies for which benefits are available under the Plan must be Medically Necessary as determined by the Claim Administrator. Charges for services and supplies which the Claim Administrator determines are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy Deductibles or to apply to the Out-of-Pocket Maximum.

ParPlan

When you consult a Physician or Professional Other Provider who does not participate in the Network, you should inquire if he participates in the Claim Administrator's *ParPlan*...a simple direct-payment arrangement. If the Physician or Professional Other Provider participates in the *ParPlan*, he agrees to:

- File all claims for you,
- Accept the Claim Administrator's Allowable Amount determination as payment for Medically Necessary services, and
- Not bill you for services over the Allowable Amount determination.

You will receive Out-of-Network Benefits and be responsible for:

- Any Deductibles,
- Co-Share Amounts, and
- Services that are limited or not covered under the Plan.

NOTE: If you have a question regarding a Physician's or Professional Other Provider's participation in the *ParPlan*, please contact the Claim Administrator's Customer Service Helpline.

Preexisting Conditions Provision

Benefits for Eligible Expenses incurred for treatment of a preexisting condition will be available immediately with no preexisting condition Waiting Period.

Specialty Care Providers

A wide range of Specialty Care Providers is included in the Network. When you need a specialist's care, In-Network Benefits will be available, but only if you use a Network Provider.

There may be occasions however, when you need the services of an Out-of-Network Provider. This could occur if you have a complex medical problem that cannot be taken care of by a Network Provider.

- If the services you require are not available from Network Providers, In-Network Benefits will be provided when you use Out-of-Network Providers.
- If you elect to see an Out-of-Network Provider and if the services could have been provided by a Network Provider, only Out-of-Network Benefits will be available.

Use of Non-Contracting Providers

When you choose to receive services, supplies, or care from a Provider that does not contract with BCBSTX (a non-contracting Provider), you receive Out-of-Network Benefits (the lower level of benefits). Benefits for covered services will be reimbursed based on the BCBSTX non-contracting Allowable Amount, which in most cases is less than the Allowable Amount applicable for BCBSTX contracted Providers. Please see the definition of non-contracting Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet. **The non-contracted Provider is not required to accept the BCBSTX non-contracting Allowable Amount as payment in full and may balance bill you for the difference between the BCBSTX non-contracting Allowable Amount and the non-contracting Provider's billed charges. You will be responsible for this balance bill amount, which may be considerable. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan, any applicable Deductibles and Co-Share amounts.**

PRAUTHORIZATION REQUIREMENTS

Preauthorization Requirements

Preauthorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the Preauthorized care and services described below will not be denied on the basis of Medical Necessity or Experimental/Investigational. However, Preauthorization does not guarantee payment of benefits.

Coverage is always subject to other requirements of the Plan, such as limitations and exclusions, payment of contributions, and eligibility at the time care and services are provided.

The following types of services require Preauthorization:

- All inpatient Hospital Admissions,
- Extended Care Expenses,
- Home Infusion Therapy,
- All inpatient treatment of Mental Health Care,
- All inpatient treatment of Serious Mental Illness,
- All inpatient treatment of Chemical Dependency, and
- If you transfer to another facility or to or from a specialty unit within the facility.
- The following outpatient treatment of Mental Health Care, Serious Mental Illness and Chemical Dependency:
 - Psychological testing,
 - Neuropsychological testing,
 - Electroconvulsive therapy, and
 - Intensive Outpatient Program.

Intensive Outpatient Program means a freestanding or Hospital-based program that provides services for at least three hours per day, two or more days per week, to treat mental illness, drug addiction, substance abuse or alcoholism, or specializes in the treatment of co-occurring mental illness with drug addiction, substance abuse or alcoholism. These programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions which make it unlikely that the Participants will benefit from programs that focus solely on mental illness conditions.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. In-Network Providers will Preauthorize services for you, when required.

If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid.

However, if care is not available from Network Providers as determined by the Claim Administrator, and the Claim Administrator acknowledges your visit to an Out-of-Network Provider **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjusted, if appropriate.

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Physician, Behavioral Health Practitioner or Provider of services must comply with the guidelines below. Failure to Preauthorize services will require additional steps and/or benefit reductions as described in the section entitled *Failure to Preauthorize*.

Preauthorization for Inpatient Hospital Admissions

In the case of an elective inpatient Hospital Admission, the call for Preauthorization should be made at least two working days before you are admitted unless it would delay Emergency Care. In an emergency, Preauthorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

To satisfy Preauthorization requirements, on business days between 7:30 a.m. and 6:00 p.m. Central Time, you, your Physician, Provider of services, or a family member should call one of the Customer Service toll-free numbers listed on the back of your Identification Card. After working hours or on weekends, please call the **Medical Preauthorization Helpline** toll-free number listed on the back of your Identification Card. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid. In-Network and Out-of-Network Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

However, if care is not available from Network Providers as determined by BCBSTX, and BCBSTX authorizes your visit to an Out-of-Network Provider to be covered at the In-Network Benefit level **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid.

When an inpatient Hospital Admission is Preauthorized, a length-of-stay is assigned. If you require a longer stay than was first Preauthorized, your Provider may seek an extension for the additional days. Benefits will not be available for room and board charges for medically unnecessary days.

Preauthorization not Required for Maternity Care and Treatment of Breast Cancer Unless Extension of Minimum Length of Stay Requested

Your Plan is required to provide a minimum length-of-stay in a Hospital facility for the following:

- Maternity Care
 - 48 hours following an uncomplicated vaginal delivery
 - 96 hours following an uncomplicated delivery by caesarean section
- Treatment of Breast Cancer
 - 48 hours following a mastectomy
 - 24 hours following a lymph node dissection

You or your Provider will not be required to obtain Preauthorization from BCBSTX for a length of stay less than 48 hours (or 96 hours) for Maternity Care or less than 48 hours (or 24 hours) for Treatment of Breast Cancer. If you require a longer stay, you or your Provider must seek an extension for the additional days by obtaining Preauthorization from BCBSTX.

Preauthorization for Extended Care Expenses and Home Infusion Therapy

Preauthorization for Extended Care Expenses and Home Infusion Therapy may be obtained by having the agency or facility providing the services contact the Claim Administrator to request Preauthorization. The request should be made:

- Prior to initiating Extended Care Expenses or Home Infusion Therapy;
- When an extension of the initially Preauthorized service is required; and
- When the treatment plan is altered.

The Claim Administrator will review the information submitted prior to the start of Extended Care Expenses or Home Infusion Therapy and will send a letter to you and the agency or facility confirming Preauthorization or denying benefits. If Extended Care Expenses or Home Infusion Therapy is to take place in less than one week, the agency or facility should call the Claim Administrator's **Medical Preauthorization Helpline** telephone number indicated in this Benefit Booklet or shown on your Identification Card.

If the Claim Administrator has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

Preauthorization for Mental Health Care, Serious Mental Illness, and Treatment of Chemical Dependency

In order to receive maximum benefits, all inpatient treatment for Mental Health Care, Serious Mental Illness, and Chemical Dependency must be Preauthorized by the Plan. Preauthorization is also required for certain outpatient

services. Outpatient services requiring Preauthorization include psychological testing, neuropsychological testing, Intensive Outpatient Programs and electroconvulsive therapy. Preauthorization is not required for therapy visits to a Physician, Behavioral Health Practitioner and/or Professional Other Provider.

To satisfy Preauthorization requirements, you, a family member or your Behavioral Health Practitioner must call the **Mental Health/Chemical Dependency Preauthorization Helpline** toll-free number indicated in this Benefit Booklet or shown on your Identification Card. The **Mental Health/Chemical Dependency Preauthorization Helpline** is available 24 hours a day, 7 days a week. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid. In-Network and Out-of-Network Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

However, if care is not available from Network Providers as determined by BCBSTX, and BCBSTX authorizes your visit to an Out-of-Network Provider to be covered at the In-Network Benefit level **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid.

When a treatment or service is Preauthorized, a length of stay or length of service is assigned. If you require a longer stay or length of service than was first Preauthorized, your Behavioral Health Practitioner may seek an extension for the additional days or visits. Benefits will not be available for medically unnecessary treatments or services.

Failure to Preauthorize

If Preauthorization for inpatient Hospital Admissions, Extended Care Expense, Home Infusion Therapy, all inpatient and the above specified outpatient treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Chemical Dependency is not obtained:

- BCBSTX will review the Medical Necessity of your treatment or service prior to the final benefit determination.
- If BCBSTX determines the treatment or service is not Medically Necessary or is Experimental/Investigational, benefits will be reduced or denied.
- You may be responsible for a penalty in connection with the following Covered Services, if indicated on your Schedule of Coverage:
 - Inpatient Hospital Admission
 - Inpatient treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Chemical Dependency

The penalty charge will be deducted from any benefit payment which may be due for Covered Services.

If an inpatient Hospital Admission, Extended Care Expense, Home Infusion Therapy, any treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Chemical Dependency or extension for any treatment or service described above is not Preauthorized and it is determined that the treatment, service, or extension was not Medically Necessary or was Experimental/Investigational, benefits will be reduced or denied.

CLAIM FILING AND APPEALS PROCEDURES

Claim Filing Procedures

Filing of Claims Required

Claim Forms

When the Claim Administrator receives notice of claim, it will furnish to you, or to your Employer for delivery to you, the Hospital, or your Physician or Professional Other Provider, the claim forms that are usually furnished by it for filing Proof of Loss.

The Claim Administrator for the Plan must receive claims prepared and submitted in the proper manner and form, in the time required, and with the information requested before it can consider any claim for payment of benefits.

Who Files Claims

Providers that contract with the Claim Administrator and some other health care Providers (such as *ParPlan* Providers) will submit your claims directly to the Claim Administrator for services provided to you or any of your covered Dependents. At the time services are provided, inquire if they will file claim forms for you. To assist Providers in filing your claims, you should carry your Identification Card with you.

Contracting Providers

When you receive treatment or care from a Provider that contracts with the Claim Administrator, you will generally not be required to file claim forms. The Provider will usually submit the claims directly to the Claim Administrator for you.

Non-Contracting Providers

When you receive treatment or care from a health care Provider that does not contract with the Claim Administrator, you may be required to file your own claim forms. Some Providers, however, will do this for you. If the Provider does not submit claims for you, refer to the subsection entitled *Participant-filed claims* below for instruction on how to file your own claim forms.

Participant-Filed Claims - Medical Claims

If your Provider does not submit your claims, you will need to submit them to the Claim Administrator using a Subscriber-filed claim form provided by the Plan. Your Employer should have a supply of claim forms or you can obtain copies from the BCBSTX website. Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant's expenses separately because any Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the health care Providers, labs, etc., printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

VISIT THE BCBSTX WEBSITE FOR SUBSCRIBER CLAIM FORMS AND OTHER USEFUL INFORMATION
www.bcbstx.com

Where to Mail Completed Claim Forms

Medical Claims

Blue Cross and Blue Shield of Texas
Claims Division
P. O. Box 660044
Dallas, TX 75266-0044

Who Receives Payment

Benefit payments will be made directly to contracting Providers when they bill the Claim Administrator. Written agreements between the Claim Administrator and some Providers may require payment directly to them.

Any benefits payable to you, if unpaid at your death, will be paid to your surviving spouse, as beneficiary. If there is no surviving spouse, then the benefits will be paid to your estate.

Except as provided in the section **Assignment and Payment of Benefits**, rights and benefits under the Plan are not assignable, either before or after services and supplies are provided.

Benefit Payments to a Managing Conservator

Benefits for services provided to your minor Dependent child may be paid to a third party if:

- the third party is named in a court order as managing or possessory conservator of the child; and
- the Claim Administrator has not already paid any portion of the claim.

In order for benefits to be payable to a managing or possessory conservator of a child, the managing or possessory conservator must submit to the Claim Administrator, with the claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator.

The Claim Administrator for the Health Benefit Plan may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to you or your Provider, or deduction by the Plan from benefit payments of amounts owed to it, will be considered in satisfaction of its obligations to you under the Plan.

An *Explanation of Benefits* summary is sent to you so you will know what has been paid.

When to Submit Claims

All claims for benefits under the Health Benefit Plan must be properly submitted to the Claim Administrator within twelve (12) months of the date you receive the services or supplies. Claims submitted and received by the Claim Administrator after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by the Claim Administrator

A claim will be considered received by the Claim Administrator for processing upon actual delivery to the Administrative Office of the Claim Administrator in the proper manner and form and with all of the information required. If the claim is not complete, it may be denied or the Claim Administrator may contact either you or the Provider for the additional information.

After processing the claim, the Claim Administrator will notify the Participant by way of an *Explanation of Benefits* summary.

Review of Claim Determinations

Claim Determinations

When the Claim Administrator receives a properly submitted claim, it has authority and discretion under the Plan to interpret and determine benefits in accordance with the Health Benefit Plan provisions. The Claim Administrator will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing between the Claim Administrator and the Plan Administrator.

You have the right to seek and obtain a full and fair review by the Claim Administrator of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by the Claim Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

If a Claim Is Denied or Not Paid in Full

On occasion, the Claim Administrator may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the *Explanation of Benefits* summary prepared by the Claim Administrator; then review this Benefit Booklet to see whether you understand the reason for the determination. If you have additional

information that you believe could change the decision, send it to the Claim Administrator and request a review of the decision as described in **Claim Appeal Procedures** below.

If the claim is denied in whole or in part, you will receive a written notice from the Claim Administrator with the following information, if applicable:

- The reasons for determination;
- A reference to the Health Benefit Plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
- A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of the Claim Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;
- In certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge upon request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- In the case of a denial of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such claims. An Urgent Care Clinical Claim decision may be provided orally, so long as a written notice is furnished to the claimant within three days of oral notification;
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of Claim. There are three types of Claims as defined below.

1. **Urgent Care Clinical Claim** is any Pre-Service Claim that requires Preauthorization, as described in this Benefit Booklet, for benefits for medical care or Treatment with respect to which the application of regular time periods for making health Claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or Treatment.
2. **Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
3. **Post-Service Claim** is notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

Urgent Care Clinical Claims*

Type of Notice or Extension	Timing
If your Claim is incomplete, the Claim Administrator must notify you within:	24 hours
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	48 hours after receiving notice
<i>The Claim Administrator must notify you of the Claim determination (whether adverse or not):</i>	
if the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than:	72 hours
after receiving the completed Claim (if the initial Claim is incomplete), within:	48 hours

* You do not need to submit Urgent Care-Clinical Claims in writing. You should call the Claim Administrator at the toll-free number listed on the back of your Identification Card as soon as possible to submit an Urgent Care Clinical Claim.

Pre-Service Claims

Type of Notice or Extension	Timing
If your Claim is filed improperly, the Claim Administrator must notify you within:	5 days
If your Claim is incomplete, the Claim Administrator must notify you within:	15 days
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	45 days after receiving notice
<i>The Claim Administrator must notify you of any adverse Claim determination:</i>	
if the initial Claim is complete, within:	15 days*
after receiving the completed Claim (if the initial Claim is incomplete), within:	30 days
If you require post-stabilization care after an Emergency within:	the time appropriate to the circumstance not to exceed one hour after the time of request

* This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

Post-Service Claims

Type of Notice or Extension	Timing
If your Claim is incomplete, the Claim Administrator must notify you within:	30 days
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	45 days after receiving notice
<i>The Claim Administrator must notify you of the Claim determination (whether adverse or not):</i>	
if the initial Claim is complete, within:	30 days*
after receiving the completed Claim (if the initial Claim is incomplete), within:	45 days

* This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

Concurrent Care

For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your Claim for benefits.

Claim Appeal Procedures

Claim Appeal Procedures - Definitions

An “**Adverse Benefit Determination**” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide in response to a claim, Pre-Service Claim or Urgent Care Clinical Claims, or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator or your Employer and the Claim Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination of the Employer’s benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination.

A “**Final Internal Adverse Benefit Determination**” means an Adverse Benefit Determination that has been upheld by the Claim Administrator or your Employer at the completion of the Claim Administrator’s or Employer’s internal review/appeal process.

Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An **expedited clinical appeal** is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, as well as continued hospitalization. Before authorization of benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, the Claim Administrator will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Claim Administrator shall render a determination on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by the Claim Administrator.

How to Appeal an Adverse Benefit Determinations

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by the Claim Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your ID card.

If you believe the Claim Administrator incorrectly denied all or part of your benefits, you may have your claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of a denial or partial denial, you may call or write to the Claim Administrator's Administrative Office. The Claim Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

Claim Review Section
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044

- You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.
- The Claim Administrator will honor telephone requests for information. However, such inquiries will not constitute a request for review.
- In support of your claim review, you have the option of presenting evidence and testimony to the Claim Administrator. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

The Claim Administrator will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. The appeal determination will be made by a Physician associated or contracted with the Claim Administrator and/or by external advisors, but who were not involved in making the initial denial of your claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator or your Employer.

- If you have any questions about the claims procedures or the review procedure, write to the Claim Administrator's Administrative Office or call the toll-free Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.

Timing of Appeal Determinations

Upon receipt of a non-urgent pre-service appeal, the Claim Administrator shall render a determination of the appeal as soon as practical, but in no event more than 30 days after the appeal has been received by the Claim Administrator.

Upon receipt of a non-urgent post-service appeal, the Claim Administrator shall render a determination of the appeal as soon as practical, but in no event more than 60 days after the appeal has been received by the Claim Administrator.

Notice of Appeal Determination

The Claim Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, by a written notice of the determination.

The written notice to you or your authorized representative will include:

1. A reason for the determination;
2. A reference to the benefit Plan provisions on which the determination is based, and the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Diagnosis/treatment codes with their meanings and the standards used are also available upon request;
4. An explanation of the Claim Administrator's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal;
5. In certain situations, a statement in non-English language(s) that written notices of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
6. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
7. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
8. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
9. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
10. A description of the standard that was used in denying the claim and a discussion of the decision;
11. Contact information for applicable office of health insurance consumer assistance or ombudsman.

If the Claim Administrator's or your Employer's decision is to continue to deny or partially deny your claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the **Standard External Review** section below.

If You Need Assistance

If you have any questions about the claims procedures or the review procedure, write or call the Claim Administrator Headquarters at 1-800-521-2227. The Claim Administrator Customer Service Helpline is accessible from 8:00 A.M. to 8:00 P.M., Monday through Friday.

Claim Review Section
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may call the number on the back of your ID card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Standard External Review

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO).

1. **Request for external review.** Within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review.
2. **Preliminary review.** Within five business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:
 - a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
 - b. The Adverse Benefit Determination or the Final Adverse Internal Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
 - c. You have exhausted the Claim Administrator's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the **Exhaustion** section below for additional information and exhaustion of the internal appeal process; and
 - d. You or your authorized representative have provided all the information and forms required to process an external review.

You will be notified within one business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

3. **Referral to Independent Review Organization.** When an eligible request for external review is completed within the time period allowed, the Claim Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the Claim Administrator will take action against bias and to ensure independence. Accordingly, the Claim Administrator must contract with at least three IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

- a. Utilization of legal experts where appropriate to make coverage determinations under the plan.
- b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
- c. Within five business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.

- d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider the Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claim Administrator.
- e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
 - (1) Your medical records;
 - (2) The attending health care professional's recommendation;
 - (3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;
 - (4) The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
 - (5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - (6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
 - (7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claim Administrator and you or your authorized representative.
- g. The notice of final external review decision will contain:
 - (1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - (2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - (3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 - (4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - (5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator or you or your authorized representative;
 - (6) A statement that judicial review may be available to you or your authorized representative; and
 - (7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

- h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.
4. **Reversal of plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claim Administrator must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

1. **Request for expedited external review.** The Claim Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claim Administrator at the time you receive:
 - a. An Adverse Benefit Determination, if the Adverse Benefit Determination involve a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
 - b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.
2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the **Standard External Review** section above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in **Standard External Review** section above.
3. **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the **Standard External Review** section above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process.

4. **Notice of final external review decision.** The Claim Administrator's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the **Standard External Review** section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

Exhaustion

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the Claim Administrator to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

Interpretation of Employer's Plan Provisions

The Plan Administrator has given the Claim Administrator the initial authority to establish or construe the terms and conditions of the Health Benefit Plan and the discretion to interpret and determine benefits in accordance with the Health Benefit Plan's provisions.

The Plan Administrator has all powers and authority necessary or appropriate to control and manage the operation and administration of the Health Benefit Plan.

All powers to be exercised by the Claim Administrator or the Plan Administrator shall be exercised in a non-discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Eligible Expenses

The Plan provides coverage for the following categories of Eligible Expenses:

- Inpatient Hospital Expenses,
- Medical-Surgical Expenses,
- Extended Care Expenses,
- special provisions expenses

Wherever Schedule of Coverage is mentioned, please refer to your Schedule(s) in this Benefit Booklet. Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

Deductibles

The benefits of the Plan will be available after satisfaction of the applicable Deductibles as shown on your Schedule of Coverage. The Deductibles may be increased in the future in direct proportion to the increase as determined from the cost-of-living adjustments based on the Consumer Price Index (CPI-U).

The Deductibles are explained as follows:

1. If “Employee Only” coverage is selected, the individual Deductible amount as shown on your Schedule of Coverage under “Deductibles,” unless otherwise indicated, will apply to all combined Inpatient Hospital Expenses, Medical-Surgical Expenses, Extended Care Expenses, and Special Provisions Expenses you incur during a Calendar Year and must be satisfied before any benefits are available under the Plan.
2. If “Family” coverage is selected, the family Deductible amount as shown on your Schedule of Coverage under “Deductibles,” unless otherwise indicated, will apply to all combined Inpatient Hospital Expenses, Medical-Surgical Expenses, Extended Care Expenses, and Special Provisions Expenses each Participant incurs during each Calendar Year and must be satisfied before any benefits are available under the Plan. The family Deductible amount may be satisfied by one Participant or a combination of two or more Participants.

The following are exceptions to the Deductibles described above:

In-Network *Preventive Care Services* are not subject to Deductibles.

Eligible Expenses applied toward satisfying the “individual” and “family” Out-of-Network Deductible will apply toward both the Out-of-Network and the In-Network Deductible. However, Eligible Expenses applied toward satisfying the “individual” and “family” In-Network Deductible will not apply toward satisfying the Out-of-Network Deductible.

Out-of-Pocket Maximum

Most of your Eligible Expense payment obligations are applied to the Out-of-Pocket Maximum. The Out-of-Pocket Maximum may be increased in the future in direct proportion to the increase as determined from the cost-of-living adjustments based on the Consumer Price Index (CPI-U).

1. The Out-of-Pocket Maximum will not include:
 - Services, supplies, or charges limited or excluded by the Plan;
 - Expenses not covered because a benefit maximum has been reached;
 - Any Eligible Expense paid by the Primary Plan when the Plan is the Secondary Plan for purposes of coordination of benefits;
 - Penalties for failing to obtain Preauthorization.
2. If you selected “Employee Only” coverage, when the “individual” “Out of-Pocket Maximum” for a Calendar Year equals the amount shown on your Schedule of Coverage, the benefit percentage automatically increases to

100% for purposes of determining the benefits available for additional Eligible Expenses incurred by you during the remainder of that Calendar Year.

3. If you selected the “Family” coverage, when the “family” “Out-of-Pocket Maximum” for a Calendar Year equals the amount shown on your Schedule of Coverage, the benefit percentage automatically increases to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by all family Participants during the remainder of that Calendar Year. The “family” “Out-of-Pocket Maximum” may be satisfied by one or more covered Participants.

The following are exceptions to the Out-of-Pocket-Maximum described above:

There are separate Out-of-Pocket Maximums for In-Network Benefits and Out-of-Network Benefits.

Eligible Expenses applied toward satisfying the “individual” and “family” Out-of-Network Out-of-Pocket Maximum will apply toward both the In-Network and Out-of-Network Out-of-Pocket Maximum amounts. However, Eligible Expenses applied toward satisfying the “individual” and “family” In-Network Out-of-Pocket Maximum amount will not apply toward satisfying the Out-of-Network Out-of-Pocket Maximum amounts.

Changes In Benefits

Changes to covered benefits will apply to all services provided to each Participant under the Plan. Benefits for Eligible Expenses incurred during an admission in a Hospital or Facility Other Provider that begins before the change will be those benefits in effect on the day of admission.

COVERED MEDICAL SERVICES

Inpatient Hospital Expenses

The Plan provides coverage for Inpatient Hospital Expenses for you and your eligible Dependents. Each inpatient Hospital Admission requires Preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for additional information.

The benefit percentage of your total eligible Inpatient Hospital Expense, in excess of any Deductible, shown under “Inpatient Hospital Expenses” on your Schedule of Coverage is the Plan’s obligation. The remaining unpaid Inpatient Hospital Expense, in excess of any Deductible, is your obligation to pay and will be applied to your Out-of-Pocket Maximum. This excess amount will be applied to the Out-of-Pocket Maximum.

Services and supplies provided by an Out-of-Network Provider will receive In-Network Benefits when those services and supplies are not available from a Network Provider provided the Claim Administrator acknowledges your visit to an Out-of-Network Provider **prior** to the visit. Otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate.

Refer to your Schedule of Coverage for information regarding Deductibles, Co-Share percentages, and penalties for failure to Preauthorize that may apply to your coverage.

Medical-Surgical Expenses

The Plan provides coverage for Medical-Surgical Expense for you and your covered Dependents. Some services require Preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

The benefit percentage of your total eligible Medical Surgical Expenses, in excess of any Deductible, shown under “Deductibles” on your Schedule of Coverage is the Plan’s obligation. The remaining unpaid Medical Surgical Expenses, including the Deductible is your obligation to pay and will be applied to the Out-of-Pocket Maximum.

Medical-Surgical Expense shall include:

1. Services of Physicians and Professional Other Providers.
2. Consultation services of a Physician and Professional Other Provider.
3. Services of a certified registered nurse-anesthetist (CRNA).
4. Diagnostic x-ray and laboratory procedures.
5. Radiation therapy.
6. Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by the Plan. The term “durable medical equipment (DME)” shall not include:
 - a. Equipment primarily designed for alleviation of pain or provision of patient comfort; or
 - b. Home air fluidized bed therapy.

Examples of non-covered equipment include, but are not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment.

7. Professional local ambulance service to the nearest Hospital appropriately equipped and staffed for treatment of the Participant’s condition.

8. Anesthetics and its administration, when performed by someone other than the operating Physician or Professional Other Provider.
9. Oxygen and its administration provided the oxygen is actually used.
10. Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Participant.
11. Prosthetic Appliances, including replacements necessitated by growth to maturity of the Participant.
12. Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces, casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.
13. Home Infusion Therapy.
14. Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or a Chemical Dependency Treatment Center, or scheduled services in the outpatient treatment room of a Hospital.
15. Certain Diagnostic Procedures.
16. Outpatient Contraceptive Services, prescription contraceptive devices and specified FDA-approved over-the-counter female contraceptives with a written prescription by a Health Care Practitioner to women with reproductive capacity as shown in *Benefits for Preventive Care Services*. The Participant will be responsible for submitting a claim form, written prescription and the itemized receipt for the over-the counter female contraceptive. Visit the BCBSTX website at www.bcbstx.com to obtain a claim form.
17. Foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes.
18. Drugs that have not been approved by the FDA for self-administration when injected, ingested or applied in a Physician's or Professional Other Provider's office.
19. Elective Abortions.
20. Elective Sterilizations.

Extended Care Expenses

The Plan also provides benefits for Extended Care Expenses for you and your covered Dependents. All Extended Care Expenses require Preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

The Plan's benefit obligation as shown on your Schedule of Coverage will be:

1. At the benefit percentage under "Extended Care Expenses," and
2. Up to the number of days or visits shown for each category of Extended Care Expenses on your Schedule of Coverage.

All payments made by the Plan, whether under the In-Network or Out-of-Network Benefit level, will apply toward the benefit maximums under both levels of benefits.

The benefit maximums will also include any benefits provided to a Participant for Extended Care Expenses under a Health Benefit Plan held by the Employer with the Claim Administrator immediately prior to the Participant's Effective Date of coverage under the Plan.

The Calendar Year Deductible will apply. Any unpaid Extended Care Expenses in excess of the benefit maximums shown on your Schedule of Coverage will not be applied to any Out-of-Pocket Maximum.

Any charges incurred as Home Health Care or home Hospice Care for drugs (including antibiotic therapy) and laboratory services will not be Extended Care Expenses but will be considered Medical-Surgical Expenses.

Services and supplies for Extended Care Expenses:

1. For Skilled Nursing Facility:

- a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
- b. Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;
- c. Physical, occupational, speech, and respiratory therapy services by licensed therapists.

2. For Home Health Care:

- a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
- b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
- c. Physical, occupational, speech, and respiratory therapy services by licensed therapists;
- d. Supplies and equipment routinely provided by the Home Health Agency.

Benefits will **not** be provided for Home Health Care for the following:

- Food or home delivered meals;
- Social case work or homemaker services;
- Services provided primarily for Custodial Care;
- Transportation services;
- Home Infusion Therapy;
- Durable medical equipment.

3. For Hospice Care:

Home Hospice Care:

- a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
- b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
- c. Physical, speech, and respiratory therapy services by licensed therapists;
- d. Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.

Facility Hospice Care:

- a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
- b. Room and board and all routine services, supplies, and equipment provided by the Hospice facility;
- c. Physical, speech, and respiratory therapy services by licensed therapists.

Special Provisions Expenses

The benefits available under this **Special Provisions Expenses** subsection are generally determined on the same basis as other Inpatient Hospital Expenses, Medical-Surgical Expenses, and Extended Care Expenses, except to the extent described in each item. Benefits for Medically Necessary expenses will be determined as indicated on your Schedule(s) of Coverage. Remember that certain services require Preauthorization and that any Co-Share percentages, and Deductibles shown on your Schedule(s) of Coverage will also apply. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

Benefits for Treatment of Complications of Pregnancy

Benefits for Eligible Expenses incurred for treatment of Complications of Pregnancy will be determined on the same basis as treatment for any other sickness. Dependent children will be eligible for treatment of Complications of Pregnancy.

Benefits for Maternity Care

Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other treatment of sickness. Dependent children will be eligible for Maternity Care benefits.

Services and supplies incurred by a Participant for delivery of a child shall be considered Maternity Care and are subject to all provisions of the Plan.

The Plan provides coverage for inpatient care for the mother and newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery; and
- 96 hours following an uncomplicated delivery by caesarean section.

If the mother or newborn is discharged before the minimum hours of coverage, the Plan provides coverage for *Postdelivery Care* for the mother and newborn. The *Postdelivery Care* may be provided at the mother's home, a health care Provider's office, or a health care facility.

Postdelivery Care means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes:

- parent education,
- assistance and training in breast-feeding and bottle feeding, and
- the performance of any necessary and appropriate clinical tests.

Charges for well-baby nursery care, including the initial examination, of a newborn child during the mother's Hospital Admission for the delivery will be considered Inpatient Hospital Expense of the child and will be subject to the benefit provisions as described under **Inpatient Hospital Expenses**. Benefits will also be subject to any Deductible amounts shown on your Schedule of Coverage.

Benefits for Emergency Care and Treatment of Accidental Injury

The Plan provides coverage for medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

If reasonably possible, contact your Network Physician or Behavioral Health Practitioner before going to the Hospital emergency room/treatment room. He can help you determine if you need Emergency Care or treatment of an Accidental Injury and recommend that care. If not reasonably possible, go to the nearest emergency facility, whether or not the facility is in the Network.

Whether you require hospitalization or not, you should notify your Network Physician or Behavioral Health Practitioner within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so he can recommend the continuation of any necessary medical services.

Benefits for Eligible Expenses for Accidental Injury or Emergency Care, including Accidental Injury or Emergency Care for Behavioral Health Services, will be determined as shown on your Schedule of Coverage. If admitted for the emergency condition immediately following the visit, Preauthorization of the inpatient Hospital Admission will be required.

All treatment received following the onset of an accidental injury or emergency care will be eligible for In-Network Benefits. For a non-emergency, In-Network Benefits will be available only if you use Network Providers. For a non-emergency, if you can safely be transferred to the care of a Network Provider but are treated by an Out-of-Network Provider, only Out-of-Network Benefits will be available.

Notwithstanding anything in this Benefit Booklet to the contrary, for Out-of-Network Emergency Care services rendered by non-contracting Providers, the Allowable Amount shall be equal to the greatest of the following three possible amounts--not to exceed billed charges:

1. the median amount negotiated with In-Network Providers for Emergency Care services furnished;
2. the amount for the Emergency Care service calculated using the same method the Plan generally uses to determine payments for Out-of-Network services but substituting the In-Network cost-sharing provisions for the Out-of-Network cost sharing provisions; or
3. the amount that would be paid under Medicare for the Emergency Care service.

Each of these three amounts is calculated excluding any Co-Share Amount imposed with respect to the Participant.

Benefits for Urgent Care

Benefits for Eligible Expenses for Urgent Care will be determined as shown on your Schedule of Coverage. Urgent Care means the delivery of medical care in a facility dedicated to the delivery of scheduled or unscheduled, walk-in care outside of a hospital emergency room/treatment room department or physician's office. The necessary medical care is for a condition that is not life-threatening.

Benefits for Early Detection Tests for Cardiovascular Disease

Benefits are available for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when performed by a laboratory that is certified by a recognized national organization:

1. Computed tomography (CT) scanning measuring coronary artery calcifications; or
2. Ultrasonography measuring carotid intima-media thickness and plaque.

Tests are available to each covered individual who is (1) a male older than 45 years of age and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 years of age. The individual must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

Benefits for Speech and Hearing Services

Benefits as shown on your Schedule of Coverage are available for the services of a Physician or Professional Other Provider to restore loss of or correct an impaired speech or hearing function.

Benefits for Certain Therapies for Children with Developmental Delays

Medical-Surgical Expense benefits are available to a covered Dependent child for the necessary rehabilitative and habilitative therapies in accordance with an Individualized Family Service Plan.

Such therapies include:

- occupational therapy evaluations and services;
- physical therapy evaluations and services;
- speech therapy evaluations and services; and
- dietary or nutritional evaluations.

The *Individualized Family Service Plan* must be submitted to the Claim Administrator prior to the commencement of services and when the Individualized Family Service Plan is altered.

Once the child reaches the age of three, when services under the *Individualized Family Service Plan* are completed, Eligible Expenses, as otherwise covered under this Plan, will be available. All contractual provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.

Developmental Delay means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:

- Cognitive development;
- Physical development;
- Communication development;
- Social or emotional development; or
- Adaptive development.

Individualized Family Service Plan means an initial and ongoing treatment plan.

Benefits for Screening Tests for Hearing Impairment

Benefits are available for Eligible Expenses incurred by a covered Dependent child:

- For a screening test for hearing loss from birth through the date the child is 30 days old; and
- Necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months.

Deductibles indicated on your Schedule of Coverage will not apply to this provision.

Benefits for Cosmetic, Reconstructive, or Plastic Surgery

The following Eligible Expenses described below for Cosmetic, Reconstructive, or Plastic Surgery will be the same as for treatment of any other sickness as shown on your Schedule of Coverage:

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant; or
- Treatment provided for reconstructive surgery following cancer surgery; or
- Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
- Surgery performed on a covered Dependent child (other than a newborn child) under the age of 19 for the treatment or correction of a congenital defect other than conditions of the breast; or
- Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy; or
- Reconstructive surgery performed on a covered Dependent child under the age of 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Benefits for Dental Services

Benefits for Eligible Expenses incurred by a Participant will be provided on the same basis as for treatment of any other sickness as shown on your Schedule of Coverage only for the following:

- Covered Oral Surgery;
- Services provided to a newborn child which are necessary for treatment or correction of a congenital defect; or
- The correction of damage caused solely by external, violent Accidental Injury to healthy, un-restored natural teeth and supporting tissues and limited to treatment provided within 24 months of the initial treatment. An injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.

Any other dental services, except as excluded in the **MEDICAL LIMITATIONS AND EXCLUSIONS** section of this Benefit Booklet, for which a Participant incurs Inpatient Hospital Expenses for a Medically Necessary inpatient Hospital Admission, will be determined as described in **Benefits for Inpatient Hospital Expenses**.

Benefits for Organ and Tissue Transplants

1. Subject to the conditions described below, benefits for covered services and supplies provided to a Participant by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:
 - a. The transplant procedure is not Experimental/Investigational in nature; and
 - b. Donated human organs or tissue or an FDA-approved artificial device are used; and
 - c. The recipient is a Participant under the Plan; and
 - d. The transplant procedure is Preauthorized as required under the Plan; and
 - e. The Participant meets all of the criteria established by the Claim Administrator in pertinent written medical policies; and
 - f. The Participant meets all of the protocols established by the Hospital in which the transplant is performed.

Covered services and supplies “related to” an organ or tissue transplant include, but are not limited to, x-rays, laboratory testing, chemotherapy, radiation therapy, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

2. Benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is considered Medically Necessary and meets all of the conditions cited above.

Benefits will be available for:

- a. A recipient who is covered under this Plan; and
 - b. A donor who is a Participant under this Plan.
3. Covered services and supplies include services and supplies provided for the:
 - a. Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and
 - b. Donor search and acceptability testing of potential live donors; and
 - c. Removal of organs or tissues from living or deceased donors; and
 - d. Transportation and short-term storage of donated organs or tissues.
4. No benefits are available for a Participant for the following services or supplies:
 - a. Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
 - b. Living and/or travel expenses of the recipient or a live donor;
 - c. Purchase of the organ or tissue; or
 - d. Organs or tissue (xenograft) obtained from another species.
5. Preauthorization is required for any organ or tissue transplant. Review the **PREAUTHORIZATION REQUIREMENTS** subsection in this Benefit Booklet for more specific information about Preauthorization.
 - a. Such specific Preauthorization is required even if the patient is already a patient in a Hospital under another Preauthorization authorization.
 - b. At the time of Preauthorization, the Claim Administrator will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if the Claim Administrator determines that an extension is Medically Necessary.
6. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which the Claim Administrator considers to be Experimental/Investigational.

Benefits for Treatment of Acquired Brain Injury

Benefits for Eligible Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Eligible Expenses include the following *services* as a result of and related to an Acquired Brain Injury:

- Cognitive communication therapy – *Services* designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information;
- Cognitive rehabilitation therapy – *Services* designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits;
- Community reintegration services – *Services* that facilitate the continuum of care as an affected individual transitions into the community;
- Neurobehavioral testing – An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others;
- Neurobehavioral treatment – Interventions that focus on behavior and the variables that control behavior;
- Neurocognitive rehabilitation – *Services* designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques;
- Neurocognitive therapy – *Services* designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities;
- Neurofeedback therapy – *Services* that utilizes operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood;
- Neurophysiological testing – An evaluation of the functions of the nervous system;
- Neurophysiological treatment – Interventions that focus on the functions of the nervous system;
- Neuropsychological testing – The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning;
- Neuropsychological treatment – Interventions designed to improve or minimize deficits in behavioral and cognitive processes;
- Post-acute transition services – *Services* that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration
- Psychophysiological testing – An evaluation of the interrelationships between the nervous system and other bodily organs and behavior;
- Psychophysiological treatment – Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors;
- Remediation – The process(es) of restoring or improving a specific function.

Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.

Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.

Benefits for Treatment of Diabetes

Benefits are available and will be determined on the same basis as any other sickness for those Medically Necessary items for *Diabetes Equipment* and *Diabetes Supplies* (for which a Physician or Professional Other Provider has written an order) and *Diabetic Management Services/Diabetes Self-Management Training*. Such items, when obtained for a *Qualified Participant*, shall include but not be limited to the following:

1. Diabetes Equipment

- a. Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind);
- b. Insulin pumps (both external and implantable) and associated appurtenances, which include:

- Insulin infusion devices,
 - Batteries,
 - Skin preparation items,
 - Adhesive supplies,
 - Infusion sets,
 - Insulin cartridges,
 - Durable and disposable devices to assist in the injection of insulin, and
 - Other required disposable supplies; and
- c. Podiatric appliances, including up to two pairs of therapeutic footwear per Calendar Year, for the prevention of complications associated with diabetes.

2. *Diabetes Supplies*

- a. Test strips specified for use with a corresponding blood glucose monitor,
 - b. Visual reading and urine test strips and tablets for glucose, ketones, and protein,
 - c. Lancets and lancet devices,
 - d. Insulin and insulin analog preparations,
 - e. Injection aids, including devices used to assist with insulin injection and needleless systems,
 - f. Biohazard disposable containers,
 - g. Insulin syringes,
 - h. Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
 - i. Glucagon emergency kits.
3. Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.
4. As new or improved treatment and monitoring equipment or supplies become available and are approved by the U. S. Food and Drug Administration (FDA), such equipment or supplies may be covered if determined to be Medically Necessary and appropriate by the treating Physician or Professional Other Provider who issues the written order for the supplies or equipment.
5. Medical-Surgical Expense provided for the nutritional, educational, and psychosocial treatment of the *Qualified Participant*. Such *Diabetic Management Services/Diabetes Self-Management Training* for which a Physician or Professional Other Provider has written an order to the Participant or caretaker of the Participant is limited to the following when rendered by or under the direction of a Physician.

Initial and follow-up instruction concerning:

- a. The physical cause and process of diabetes;
- b. Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;
- c. Prevention and treatment of special health problems for the diabetic patient;
- d. Adjustment to lifestyle modifications; and
- e. Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

Diabetes Self-Management Training for the *Qualified Participant* will include the development of an individualized management plan that is created for and in collaboration with the *Qualified Participant* (and/or his or her family) to understand the care and management of diabetes, including nutritional counseling and proper use of *Diabetes Equipment* and *Diabetes Supplies*.

A *Qualified Participant* means an individual eligible for coverage under this Plan who has been diagnosed with (a) insulin dependent or non-insulin dependent diabetes, (b) elevated blood glucose levels induced by pregnancy, or (c) another medical condition associated with elevated blood glucose levels.

Benefits for Physical Medicine Services

Benefits for Medical-Surgical Expenses incurred for Physical Medicine Services are available and will be determined on the same basis as treatment for any other sickness shown on your Schedule of Coverage.

Benefits for Chiropractic Services

Benefits for Medical-Surgical Expenses incurred for Chiropractic Services are available and will be determined on the same basis as treatment for any other sickness shown on your Schedule of Coverage.

Benefits for Routine Patient Costs for Participants in Certain Clinical Trials

Benefits for Eligible Expenses for Routine Patient Care Costs, as defined in the Definitions Section, are provided in connection with a phase I, phase II, phase III, or Phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by:

- the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
- the National Institutes of Health (NIH);
- Centers for Medicare and Medicaid Services;
- Agency for Healthcare Research and Quality;
- A cooperative group or center of any of the previous entities;
- the United States Food and Drug Administration;
- the United States Department of Defense (DOD);
- the United States Department of Veterans Affairs (VA);
- a qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants or the DOD, VA or Department of Energy if the study has been reviewed and approved through a peer review system; or
- an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protection of the United States Department of Health and Human Services.

Benefits are not available under this section for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the Research Institution conducting the clinical trial.

Benefits for Preventive Care Services

Preventive Care Services will be provided for the following covered services:

- a. evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);
- b. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;
- c. evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents; and
- d. with respect to women, such additional preventive care and screenings, not described in item a. above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The Preventive Care Services listed in items a. through d. above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the website at www.bcbstx.com or contact customer service at the toll-free number on your Identification Card.

Examples of covered services included are routine annual physicals; immunizations; well-child care; breastfeeding support, services and supplies; cancer screening mammograms; bone density test; screening for prostate cancer and colorectal cancer; smoking cessation counseling services; healthy diet counseling; and obesity screening/counseling.

Examples of covered immunizations included are Diphtheria, Haemophilus influenzae type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella and any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

Examples of covered services for women with reproductive capacity are female sterilization procedures and Outpatient Contraceptive Services; FDA-approved over-the-counter female contraceptives with a written prescription by a Health Care Practitioner; and specified FDA-approved contraception methods with a written prescription by a Health Care Practitioner from the following categories: progestin-only contraceptives, combination contraceptives, emergency contraceptives, extended cycle/continuous oral contraceptives, cervical caps, diaphragms, implantable contraceptives, intra-uterine devices, injectables, transdermal contraceptives and vaginal contraceptive devices. To determine if a specific contraceptive drug or device is included in this benefit, refer to the Women's Preventive Health Services – Contraceptive Information page located on the website at www.bcbstx.com/affordable_care_act/provisions.html or contact Customer Service at the toll-free number on your Identification Card. The list may change as FDA guidelines are modified.

Benefits are not available under this benefit provision for contraceptive drugs and devices not listed on the Women's Preventive Health Services – Contraceptive Information page. You may, however, have coverage under other sections of this Benefit Booklet, subject to any applicable Co-Share Amounts, Deductibles, and/or benefit maximums.

Preventive Care Services provided by an In-Network Provider for the items a. through d. above and/or the Women's Preventive Health Services – Contraceptive Information List will not be subject to Co-Share Amounts, Deductibles, and/or dollar maximums.

Preventive Care Services provided by an Out-of-Network Provider for the items a. through d. above and/or the Women's Preventive Health Services – Contraceptive Information List will be subject to Co-Share Amounts, Deductibles and/or applicable dollar maximums.

Covered services not included in items a. through d. above and/or the Women's Preventive Health Services – Contraceptive Information List will be subject to Co-Share Amounts, Deductibles and/or applicable dollar maximums.

Benefits for Breastfeeding Support, Services and Supplies

Benefits will be provided for breastfeeding counseling and support services when rendered by a Provider, during pregnancy and/or in the post-partum period. Benefits include the rental (or at the Plan's option, the purchase) of manual or electric breast pumps, accessories and supplies. Limited benefits are also included for the rental only of hospital grade breast pumps. You may be required to pay the full amount and submit a claim form to BCBSTX with a written prescription and the itemized receipt for the manual, electric or hospital grade breast pump, accessories and supplies. Visit the BCBSTX website at www.bcbstx.com to obtain a claim form.

If you use an Out-of-Network Provider, the benefits may be subject to any applicable Deductible, Co-Share and/or benefit maximum.

Contact Customer Service at the toll-free number on the back of your Identification Card for additional information.

Benefits for Mammography Screening

Benefits are available for a screening by low-dose mammography for the presence of occult breast cancer for a Participant, as shown in ***Preventive Care Services*** on your Schedule of Coverage, except that benefits will not be available for more than one routine mammography screening each Calendar Year.

Benefits for Detection and Prevention of Osteoporosis

If a Participant is a *Qualified Individual*, benefits are available for medically accepted bone mass measurement for the detection of low bone mass and to determine a Participant's risk of osteoporosis and fractures associated with osteoporosis, as shown in ***Preventive Care Services*** on your Schedule of Coverage.

Qualified Individual means:

1. A postmenopausal woman not receiving estrogen replacement therapy;
2. An individual with:
 - vertebral abnormalities,
 - primary hyperparathyroidism, or
 - a history of bone fractures; or
3. An individual who is:
 - receiving long-term glucocorticoid therapy, or
 - being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Benefits for Tests for Detection of Colorectal Cancer

Benefits are available for a diagnostic, medically recognized screening examination for the detection of colorectal cancer, for Participants who are 50 years of age or older and who are at normal risk for developing colon cancer, include:

- A fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years; or
- A colonoscopy performed every ten years.

Benefits will be provided for Physician Services, as shown in ***Preventive Care Services*** on your Schedule of Coverage.

Benefits for Certain Tests for Detection of Human Papillomavirus and Cervical Cancer

Benefits are available for certain tests for detection of Human Papillomavirus and Cervical Cancer for each woman enrolled in the Plan who is 18 years of age or older, for an annual medically recognized diagnostic examination for the early detection of cervical cancer, as shown in ***Preventive Care Services*** on your Schedule of Coverage. Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

Benefits for Certain Tests for Detection of Prostate Cancer

Benefits are available, as shown in ***Preventive Care Services*** on your Schedule of Coverage, for an annual medically recognized diagnostic physical examination for the detection of prostate cancer and a prostate-specific antigen test used for the detection of prostate cancer for each male under the Plan who is at least:

- 50 years of age and asymptomatic; or
- 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Benefits for Morbid Obesity

Benefits for Eligible Expenses incurred by a Participant for the Medically Necessary treatment of Morbid Obesity will be provided on the same basis as for any other sickness. Benefits are available for healthy diet counseling and obesity screening/counseling as shown in ***Preventive Care Services*** on your Schedule of Coverage.

Benefits for Other Routine Services

Benefits for other routine services are available for the following as indicated on your Schedule of Coverage:

- x-rays;
- annual hearing examinations, except for benefits as provided under ***Benefits for Screening Tests for Hearing Impairment***; and
- annual vision examinations.

Behavioral Health Services

Benefits for Mental Health Care, Treatment of Serious Mental Illness and Treatment of Chemical Dependency

Benefits for Eligible Expenses incurred for Mental Health Care, treatment of Serious Mental Illness and treatment of Chemical Dependency will be the same as for treatment of any other sickness. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection to determine what services require Preauthorization.

Any Eligible Expenses incurred for the services of a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents for Medically Necessary Mental Health Care or treatment of Serious Mental Illness in lieu of inpatient hospital services will, for the purpose of this benefit, be considered **Inpatient Hospital Expenses**.

Inpatient treatment of Chemical Dependency must be provided in a Chemical Dependency Treatment Center. However, treatment in a Hospital for the medical management of acute life-threatening intoxication (toxicity) will be an exception to this provision.

MEDICAL LIMITATIONS AND EXCLUSIONS

The benefits as described in this Benefit Booklet are not available for:

1. Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.
2. Any Experimental/Investigational services and supplies.
3. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by the Claim Administrator.
4. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
5. Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
6. Any services or supplies for which a Participant is not required to make payment or for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage, except services or supplies for treatment of mental illness or mental retardation provided by a tax supported institution of the State of Texas.
7. Any services or supplies provided by a person who is related to the Participant by blood or marriage.
8. Any services or supplies provided for injuries sustained:
 - As a result of war, declared or undeclared, or any act of war; or
 - While on active or reserve duty in the armed forces of any country or international authority.
9. Any charges:
 - Resulting from the failure to keep a scheduled visit with a Physician or Professional Other Provider; or
 - For completion of any insurance forms; or
 - For acquisition of medical records.
10. Room and board charges incurred during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Participant's physical condition or the quality of medical care provided.
11. Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage.
12. Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Plan for:
 - ***Preventive Care Services*** as shown on your Schedule of Coverage; or
 - an inpatient nutritional assessment program provided in and by a Hospital and approved by the Claim Administrator; or
 - ***Benefits for Treatment of Diabetes*** as described in **Special Provisions Expenses**; or
 - ***Benefits for Certain Therapies for Children with Developmental Delays*** as described in **Special Provisions Expenses**.

13. Any services or supplies provided for Custodial Care.
14. Any non-surgical (dental restorations, orthodontics, or physical therapy) or non-diagnostic services or supplies (oral appliances, oral splints, oral orthotics, devices, or prosthetics) provided for the treatment of the temporomandibular joint (including the jaw and craniomandibular joint) and all adjacent or related muscles.
15. Any items of Medical-Surgical Expenses incurred for dental care and treatments, dental surgery, or dental appliances, except as provided for in the ***Benefits for Dental Services*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
16. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as provided for in the ***Benefits for Cosmetic, Reconstructive, or Plastic Surgery*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
17. Any services or supplies provided for:
 - Treatment of myopia and other errors of refraction, including refractive surgery; or
 - Orthoptics or visual training; or
 - Eyeglasses or contact lenses, provided that intraocular lenses shall be specific exceptions to this exclusion; or
 - Examinations for the prescription or fitting of eyeglasses or contact lenses; or
 - Restoration of loss or correction to an impaired speech or hearing function, including hearing aids, except as may be provided under the ***Benefits for Speech and Hearing Services*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
18. Except as specifically included as an Eligible Expense, any Medical Social Services, any outpatient family counseling and/or therapy, bereavement counseling, vocational counseling, or Marriage and Family Therapy and/or marriage counseling.
19. Any services or supplies provided for treatment of adolescent behavior disorders, including conduct disorders and opposition disorders.
20. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function, except as may be provided under the ***Benefits for Physical Medicine Services*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
21. Travel or ambulance services because it is more convenient for the patient than other modes of transportation whether or not recommended by a Physician or Professional Other Provider.
22. Any services or supplies provided primarily for:
 - Environmental Sensitivity;
 - Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
 - Inpatient allergy testing or treatment.
23. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
24. Any services or supplies provided for, in preparation for, or in conjunction with:
 - Sterilization reversal (male or female);
 - Transsexual surgery;
 - Sexual dysfunctions;
 - In vitro fertilization; and
 - Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.

25. Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of severe systemic disease.
26. Any services or supplies in connection with foot care for flat feet, fallen arches, and chronic foot strain.
27. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
28. Supplies for smoking cessation programs and the treatment of nicotine addiction.
29. Any services or supplies provided for the following treatment modalities:
 - acupuncture;
 - intersegmental traction;
 - surface EMGs;
 - spinal manipulation under anesthesia; and
 - muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
30. Any services or supplies furnished by a Contracting Facility for which such facility had not been specifically approved to furnish under a written contract or agreement with the Claim Administrator will be paid at the Out-of-Network benefit level.
31. Any items that include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a Physician in a non-hospital setting or purchased “over the counter” for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts.

NOTE: This exclusion does not apply to podiatric appliances when provided as Diabetic Equipment.
32. Any benefits in excess of any specified dollar, day/visit, or Calendar Year maximums.
33. Any services and supplies provided to a Participant incurred outside the United States if the Participant traveled to the location for the purposes of receiving medical services, supplies, or drugs.
34. Donor expenses for a Participant in connection with an organ and tissue transplant if the recipient is not covered under this Plan.
35. Replacement Prosthetic Appliances except those necessitated by growth due to maturity of the Participant.
36. Private duty nursing services, except for covered Extended Care Expenses.
37. Any outpatient prescription or nonprescription drugs (except for contraceptive drugs with a written prescription by a Health Care Practitioner provided under the **COVERED MEDICAL SERVICES** portion of this Plan as shown in *Benefits for Preventive Care Services*).
38. Any non-prescription contraceptive medications or devices for male use.
39. Any drugs and medicines purchased for use outside a Hospital which require a written prescription for purchase other than injectable drugs not approved by the FDA for self-administration that are administered by or under the direct supervision of a Physician or Professional Other Provider.
40. Any services or supplies provided for reduction mammoplasty.
41. Any non-surgical services or supplies provided for reduction of obesity or weight, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight.

42. Biofeedback (except for an Acquired Brain Injury diagnosis) or other behavior modification services.
43. Any related services to a non-covered service. Related services are:
- a. services in preparation for the non-covered service;
 - b. services in connection with providing the non-covered service;
 - c. hospitalization required to perform the non-covered service; or
 - d. services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.
44. Any services or supplies not specifically defined as Eligible Expenses in this Plan.

DEFINITIONS

The definitions used in this Benefit Booklet apply to all coverage unless otherwise indicated.

Accidental Injury means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a Physician or Professional Other Provider.

Acquired Brain Injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Allowable Amount means the maximum amount determined by the Claim Administrator (BCBSTX) to be eligible for consideration of payment for a particular service, supply, or procedure.

- ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers contracting with the Claim Administrator in Texas or any other Blue Cross and Blue Shield Plan*** – The Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.
- ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers not contracting with the Claim Administrator in Texas*** – The Allowable Amount will be the lesser of: (i) the Provider's billed charges, or; (ii) the BCBSTX non-contracting Allowable Amount. Except as otherwise provided in this section, the non-contracting Allowable Amount is developed from base Medicare Participating reimbursements adjusted by a predetermined factor established by the Claim Administrator. Such factor shall be not less than 75% and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

Notwithstanding the preceding sentence, the non-contracting Allowable Amount for Home Health Care is developed from base Medicare national per visit amounts for low utilization payment adjustment, or LUPA, episodes by Home Health discipline type adjusted for duration and adjusted by a predetermined factor established by the Claim Administrator. Such factor shall be not less than 75% and shall be updated on a periodic basis.

When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on the claim, the Allowable Amount for non-contracting Providers will represent an average contract rate in aggregate for Network Providers adjusted by a predetermined factor established by the Claim Administrator. Such factor shall be not less than 75% and shall be updated not less than every two years.

The Claim Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by non-contracted Providers which may also alter the Allowable Amount for a particular service. In the event the Claim Administrator does not have any claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Amount will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within ninety (90) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

The non-contracting Allowable Amount does not equate to the Provider's billed charges and Participants receiving services from a non-contracted Provider will be responsible for the difference between the non-contracting Allowable Amount and the non-contracted Provider's billed charge, and this difference may be considerable. To find out the BCBSTX non-contracting Allowable Amount for a particular service, Participants may call customer service at the number on the back of your BCBSTX Identification Card.

- ***For multiple surgeries*** – The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus a determined percentage of the Allowable Amount for each of the other covered procedures performed.

- ***For procedures, services, or supplies provided to Medicare recipients*** – The Allowable Amount will not exceed Medicare’s limiting charge.

Average Wholesale Price means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

Behavioral Health Practitioner means a Physician or Professional Other Provider who renders services for Mental Health Care, Serious Mental Illness or Chemical Dependency, only as listed in this Benefit Booklet.

Calendar Year means the period commencing on January 1 and ending on the next succeeding December 31, inclusive.

Certain Diagnostic Procedures means:

- Bone Scan
- Cardiac Stress Test
- CT Scan (with or without contrast)
- MRI (Magnetic Resonance Imaging)
- Myelogram
- PET Scan (Positron Emission Tomography)

Chemical Dependency means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

Chemical Dependency Treatment Center means a facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Behavioral Health Practitioner and which facility is also:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
2. Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
3. Licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
4. Licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

Chiropractic Services means any of the following services, supplies or treatment provided by or under the direction of a Doctor of Chiropractic acting within the scope of his license: general office services, general services provided in an outpatient facility setting, x-rays, supplies, and physical treatment. Physical treatment includes functional occupational therapy, physical/mechano therapy, muscle manipulation therapy and hydrotherapy.

Claim Administrator means Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX, as part of its duties as Claim Administrator, may subcontract portions of its responsibilities.

Clinical Ecology means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:

1. Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);
2. Urine auto injection (injecting one’s own urine into the tissue of the body);
3. Skin irritation by Rinkel method;
4. Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or
5. Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

Complications of Pregnancy means:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac

decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but *shall not include* false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy, and

2. Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution with which the Claim Administrator has executed a written contract for the provision of care, services, or supplies furnished within the scope of its license for benefits available under the Plan. A Contracting Facility shall also include a Hospital or Facility Other Provider located outside the State of Texas, and with which any other Blue Cross Plan has executed such a written contract; provided, however, any such facility that fails to satisfy each and every requirement contained in the definition of such institution or facility as provided in the Plan shall be deemed a Non-Contracting Facility regardless of the existence of a written contract with another Blue Cross Plan.

Co-Share Amount means the dollar amount of Eligible Expenses during a Calendar Year to be applied toward the Out-of-Pocket Maximum.

Cosmetic, Reconstructive, or Plastic Surgery means surgery that:

1. Can be expected or is intended to improve the physical appearance of a Participant; or
2. Is performed for psychological purposes; or
3. Restores form but does not correct or materially restore a bodily function.

Covered Oral Surgery means maxillofacial surgical procedures limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
2. Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology;
3. Incision and drainage of facial abscess; and
4. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses.

Creditable Coverage means coverage provided under:

1. A group health plan that is a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974;
2. Health insurance coverage consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital, or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes:
 - a. group health insurance coverage;
 - b. individual health insurance coverage; and
 - c. short-term, limited-duration insurance;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid) other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines);
5. Title 10 Chapter 55, *United States Code* (medical and dental care for members and certain former members of the uniformed services and for their dependents);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A State health benefits risk pool;
8. A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program);
9. A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;

10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504 (e)); or
11. Title XXI of the Social Security Act (State Children's Health Insurance Program).

Creditable Coverage does not include:

1. Coverage only for accident (including accidental death and dismemberment);
2. Disability income coverage;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Coverage issued as a supplement to liability insurance;
5. Workers' compensation or similar coverage;
6. Automobile medical payment insurance;
7. Credit-only insurance (for example, mortgage insurance);
8. Coverage for onsite medical clinics;
9. Limited scope dental benefits, vision benefits, or long-term care benefits if they are provided under a separate policy, certificate, or contract of insurance.
10. Flexible spending accounts (FSAs) if they meet the definition of a health FSA in IRC Sec. 106(c)(2) and (a) the maximum benefit payable for the employee under the FSA for the year does not exceed two times the employee's salary reduction election under the FSA for the year; and (b) the employee has other coverage available under a group health plan of the employer for the year; and (c) the other coverage is not limited to benefits that are excepted benefits;
11. Coverage for only a specified disease or illness or Hospital indemnity or other fixed indemnity insurance;
12. Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), also known as Medigap or MedSupp insurance);
13. Coverage supplemental to the coverage provided under Chapter 55, Title 10, *United States Code* (also known as TRICARE supplemental programs); and
14. Similar supplemental coverage provided to coverage under a group health plan.

Crisis Stabilization Unit or Facility means an institution which is appropriately licensed and accredited as a Crisis Stabilization Unit or Facility for the provision of Mental Health Care and Serious Mental Illness services to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

Custodial Care means care comprised of services and supplies, including room and board and other institutional services, provided to a Participant primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or injury. *Custodial Care* is care which is not a necessary part of medical treatment for recovery, and shall include, but not be limited to, helping a Participant walk, bathe, dress, eat, prepare special diets, and take medication.

Deductible means the dollar amount of Eligible Expenses that must be incurred by a Participant, if "Individual Coverage" is elected, before benefits under this Plan will be available. If "Family Coverage" is elected, Deductible means the dollar amount of Eligible Expenses that must be incurred by the family before benefits under the Plan will be available.

Dependent means your spouse, or your Domestic Partner (you may be required to submit a certified copy of a marriage certificate or an affidavit of Domestic Partnership at the time of enrollment), or any *child* covered under the Plan who is:

1. Under the Dependent child limiting age shown on your Schedule of Coverage;
2. A *child* of any age who is medically certified as disabled and dependent on the parent for support and maintenance (provided they were covered prior to reaching the Dependent limiting age).

Child means:

- a. Your natural child; or
- b. Your legally adopted child, including a child for whom the Participant is a party in a suit in which the adoption of the child is sought; or

- c. Your stepchild; or
- d. Your foster child; or
- e. A child of your Domestic Partner; or
- f. A child of your child who is your dependent for federal income tax purposes at the time application of coverage of the child of your child is made; or
- g. A child not listed above:
 - (1) whose primary residence is your household; and
 - (2) to whom you are legal guardian or related by blood or marriage; and
 - (3) who is dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

For purposes of this Plan, the term *Dependent* will also include those individuals who no longer meet the definition of a Dependent, but are beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Dietary and Nutritional Services means the education, counseling, or training of a Participant (including printed material) regarding:

- 1. Diet;
- 2. Regulation or management of diet; or
- 3. The assessment or management of nutrition.

Domestic Partner means a person with whom you have entered into a Domestic Partnership in accordance with the guidelines established by the Plan in its affidavit or certification of Domestic Partnership. For purposes of this Plan, Domestic Partners are not eligible beneficiaries for continuation under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). For specific criteria or necessary forms required to establish eligibility for benefit coverage under this Plan, contact your Employer or Human Resources Department.

Domestic Partnership means, for purposes of this Plan, a committed relationship of mutual caring and support between two people who are jointly responsible for each other's common welfare and share financial obligations and who have executed an affidavit or certification of Domestic Partnership form provided by the Plan.

Durable Medical Equipment Provider means a Provider that provides therapeutic supplies and rehabilitative equipment and is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Effective Date means the date the coverage for a Participant actually begins. It may be different from the Eligibility Date.

Eligibility Date means the date the Participant satisfies the definition of either "Employee" or "Dependent" and is in a class eligible for coverage under the Plan as described in the **WHO GETS BENEFITS** section of this Benefit Booklet.

Eligible Expenses mean Inpatient Hospital Expenses, Medical-Surgical Expenses, Extended Care Expenses, and Special Provisions Expenses as described in this Benefit Booklet.

Emergency Care means health care services provided in a Hospital emergency facility (emergency room) or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

1. placing the patient's health in serious jeopardy;
2. serious impairment of bodily functions;
3. serious dysfunction of any bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Employee means a person who:

1. Regularly provides personal services at the Employee's usual and customary place of employment with the Employer; and
2. Works a specified number of hours per week or month as required by the Employer; and
3. Is recorded as an Employee on the payroll records of the Employer; and
4. Is compensated for services by salary or wages. If applicable to this group, proprietors, partners, corporate officers and directors need not be compensated for services by salary or wages.

For purposes of this plan, the term *Employee* will also include those individuals who are no longer an Employee of the Employer, but who are participants covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Employer means the person, firm, or institution named on this Benefit Booklet.

Environmental Sensitivity means the inpatient or outpatient treatment of allergic symptoms by:

1. Controlled environment; or
2. Sanitizing the surroundings, removal of toxic materials; or
3. Use of special non-organic, non-repetitive diet techniques.

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, *medical treatment* includes medical, surgical, or dental treatment.

Standard medical treatment means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the Hospital or Facility Other Provider in which they were performed; and
- the Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The Claim Administrator for the Plan shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination.

Although a Physician or Professional Other Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, the Claim Administrator still may determine such services or supplies to be Experimental/Investigational within this definition. Treatment provided as part of a clinical trial or a research study is Experimental/Investigational.

Extended Care Expenses means the Allowable Amount of charges incurred for those Medically Necessary services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice as described in the **Extended Care Expenses** portion of this Benefit Booklet.

Group Health Plan (GHP) as applied to this Benefit Booklet means a self-funded employee welfare benefit plan as defined in subsection 160.103 of HIPAA. For additional information, refer to the definition of Plan Administrator.

Health Benefit Plan means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a Health Maintenance Organization that provides benefits for health care services. The term does not include:

1. Accident only or disability income insurance, or a combination of accident-only and disability income insurance;
2. Credit-only insurance;
3. Disability insurance coverage;
4. Coverage for a specified disease or illness;
5. Medicare services under a federal contract;
6. Medicare supplement and Medicare Select policies regulated in accordance with federal law;
7. Long-term care coverage or benefits, home health care coverage or benefits, nursing home care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;
8. Coverage that provides limited-scope dental or vision benefits;
9. Coverage provided by a single service health maintenance organization;
10. Coverage issued as a supplement to liability insurance;
11. Workers' compensation or similar insurance;
12. Automobile medical payment insurance coverage;
13. Jointly managed trusts authorized under 29 U.S.C. Section 141, et seq., that;
 - contain a plan of benefits for employees
 - is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees, and
 - is authorized under 29 U.S.C. Section 157;
14. Hospital indemnity or other fixed indemnity insurance;
15. Reinsurance contracts issued on a stop-loss, quota-share, or similar basis;
16. Short-term major medical contracts;
17. Liability insurance, including general liability insurance and automobile liability insurance;
18. Other coverage that is:
 - similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other insurance benefits; and
 - specified in federal regulations;
19. Coverage for onsite medical clinics; or
20. Coverage that provides other limited benefits specified by federal regulations.

Health Care Practitioner means an Advanced Practice Nurse, Doctor of Medicine, Doctor of Dentistry, Physician Assistant, Doctor of Osteopathy, Doctor of Podiatry, or other licensed person with prescription authority.

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Home Health Agency means a business that provides Home Health Care and is licensed, approved, or certified by the appropriate agency of the state in which it is located or is certified by Medicare as a supplier of Home Health Care.

Home Health Care means the health care services for which benefits are provided under the Plan when such services are provided during a visit by a Home Health Agency to patients confined at home due to a sickness or injury requiring skilled health services on an intermittent, part-time basis.

Home Infusion Therapy means the administration of fluids, nutrition, or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:

1. Drugs and IV solutions;

2. Pharmacy compounding and dispensing services;
3. All equipment and ancillary supplies necessitated by the defined therapy;
4. Delivery services;
5. Patient and family education; and
6. Nursing services.

Over-the-counter products which do not require a Physician's or Professional Other Provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Home Infusion Therapy Provider means an entity that is duly licensed by the appropriate state agency to provide Home Infusion Therapy.

Hospice means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which is:

1. Licensed in accordance with state law (where the state law provides for such licensing); or
2. Certified by Medicare as a supplier of Hospice Care.

Hospice Care means services for which benefits are provided under the Plan when provided by a Hospice to patients confined at home or in a Hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

Hospital means a short-term acute care facility which:

1. Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital provider under Medicare;
2. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians or Behavioral Health Practitioners for compensation from its patients;
3. Has organized departments of medicine and major surgery, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, and maintains clinical records on all patients;
4. Provides 24-hour nursing services by or under the supervision of a Registered Nurse;
5. Has in effect a Hospital Utilization Review Plan; and
6. Is not, other than incidentally, a Skilled Nursing Facility, nursing home, Custodial Care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the treatment of Chemical Dependency, Hospice, or place for the provision of rehabilitative care.

Hospital Admission means the period between the time of a Participant's entry into a Hospital or a Chemical Dependency Treatment Center as a *Bed patient* and the time of discontinuance of bed-patient care or discharge by the admitting Physician, Behavioral Health Practitioner or Professional Other Provider, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a Hospital Admission. If a Participant is admitted to and discharged from a Hospital within a 24-hour period but is confined as a *Bed patient* in a bed accommodation during the period of time he is confined in the Hospital, the admission shall be considered a Hospital Admission by the Claim Administrator.

Bed patient means confinement in a bed accommodation of a Chemical Dependency Treatment Center on a 24-hour basis or in a bed accommodation located in a portion of a Hospital which is designed, staffed, and operated to provide acute, short-term Hospital care on a 24-hour basis; the term does not include confinement in a portion of the Hospital

(other than a Chemical Dependency Treatment Center) designed, staffed, and operated to provide long-term institutional care on a residential basis.

Identification Card means the card issued to the Employee by the Claim Administrator of the Plan indicating pertinent information applicable to his coverage.

Imaging Center means a Provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the *Department of State Health Services Certificate of Equipment Registration and/or Department of State Health Services Radioactive Materials License*.

Independent Laboratory means a Medicare certified laboratory that provides technical and professional anatomical and/or clinical laboratory services.

In-Network Benefits means the benefits available under the Plan for services and supplies that are provided by a Network Provider or an Out-of-Network Provider when acknowledged by the Claim Administrator.

Inpatient Hospital Expense means the Allowable Amount incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided that such items are:

1. Furnished at the direction or prescription of a Physician, Behavioral Health Practitioner or Professional Other Provider; and
2. Provided by a Hospital or a Chemical Dependency Treatment Center; and
3. Furnished to and used by the Participant during an inpatient Hospital Admission.

An expense shall be deemed to have been incurred on the date of provision of the service for which the charge is made.

Inpatient Hospital Expense shall include:

1. Room accommodation charges. If the Participant is in a private room, the amount of the room charge in excess of the Hospital's average semiprivate room charge *is not* an Eligible Expense.
2. All other usual Hospital services, including drugs and medications, which are Medically Necessary and consistent with the condition of the Participant. Personal items *are not* an Eligible Expense.

Medically Necessary Mental Health Care or treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents, in lieu of hospitalization, shall be Inpatient Hospital Expense.

Late Enrollee means any Employee or Dependent eligible for enrollment who requests enrollment in an Employer's Health Benefit Plan (1) after the expiration of the initial enrollment period established under the terms of the first plan for which that Participant was eligible through the Employer, (2) after the expiration of an Open Enrollment Period, or (3) after the expiration of a special enrollment period.

An Employee or a Dependent is *not* a Late Enrollee if:

1. The individual:
 - a. Was covered under another Health Benefit Plan or self-funded Health Benefit Plan at the time the individual was eligible to enroll; and
 - b. Declines in writing, at the time of initial eligibility, stating that coverage under another Health Benefit Plan or self-funded Health Benefit Plan was the reason for declining enrollment; and
 - c. Has lost coverage under another Health Benefit Plan or self-funded Health Benefit Plan as a result of:
 - (1) termination of employment;

- (2) reduction in the number of hours of employment;
 - (3) termination of the other plan's coverage;
 - (4) termination of contributions toward the premium made by the Employer;
 - (5) COBRA coverage has been exhausted;
 - (6) cessation of Dependent status;
 - (7) the Plan no longer offers any benefits to the class of similarly situated individuals that include the individual; or
 - (8) in the case of coverage offered through an HMO, the individual no longer resides, lives, or works in the service area of the HMO and no other benefit option is available; and
- d. Requests enrollment not later than the 31st day after the date on which coverage under the other Health Benefit Plan or self-funded Health Benefit Plan terminates or in the event of the attainment of a lifetime limit on all benefits, the individual must request to enroll not later than 31 days after a claim is denied due to the attainment of a lifetime limit on all benefits.
2. The request for enrollment is made by the individual within the 60th day after the date on which coverage under Medicaid or CHIP terminates.
 3. The individual is employed by an Employer who offers multiple Health Benefit Plans and the individual elects a different Health Benefit Plan during an Open Enrollment Period.
 4. A court has ordered coverage to be provided for a spouse under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the court order is issued.
 5. A court has ordered coverage to be provided for a child under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the Employer receives notice of the court order.
 6. A Dependent child is not a Late Enrollee if the child:
 - a. Was covered under Medicaid or the Children's Health Insurance Program (CHIP) at the time the child was eligible to enroll;
 - b. The employee declined coverage for the child in writing, stating that coverage under Medicaid or CHIP was the reason for declining coverage;
 - c. The child has lost coverage under Medicaid or CHIP; and
 - d. The request for enrollment is made within the 60th day after the date on which coverage under Medicaid or CHIP terminates.

Marriage and Family Therapy means the provision of professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.

Maternity Care means care and services provided for treatment of the condition of pregnancy, other than Complications of Pregnancy.

Medical Social Services means those social services relating to the treatment of a Participant's medical condition. Such services include, but are not limited to assessment of the:

1. Social and emotional factors related to the Participant's sickness, need for care, response to treatment, and adjustment to care; and
2. Relationship of the Participant's medical and nursing requirements to the home situation, financial resources, and available community resources.

Medical-Surgical Expenses means the Allowable Amount for those charges incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided such items are:

1. Furnished by or at the direction or prescription of a Physician, Behavioral Health Practitioner or Professional Other Provider; and
2. Not included as an item of Inpatient Hospital Expense or Extended Care Expense in the Plan.

A service or supply is furnished at the direction of a Physician, Behavioral Health Practitioner or Professional Other Provider if the listed service or supply is:

1. Provided by a person employed by the directing Physician, Behavioral Health Practitioner or Professional Other Provider; and
2. Provided at the usual place of business of the directing Physician, Behavioral Health Practitioner or Professional Other Provider; and
3. Billed to the patient by the directing Physician, Behavioral Health Practitioner or Professional Other Provider.

An expense shall have been incurred on the date of provision of the service for which the charge is made.

Medically Necessary or **Medical Necessity** means those services or supplies covered under the Plan which are:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and
2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
3. Not primarily for the convenience of the Participant, his Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider; and
4. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.

The medical staff of the Claim Administrator shall determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Physician, Behavioral Health Practitioner or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

Mental Health Care means any one or more of the following:

1. The diagnosis or treatment of a mental disease, disorder, or condition listed in the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*, as revised, or any other diagnostic coding system as used by the Claim Administrator, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin;
2. The diagnosis or treatment of any symptom, condition, disease, or disorder by a Physician, Behavioral Health Practitioner or Professional Other Provider (or by any person working under the direction or supervision of a Physician, Behavioral Health Practitioner or Professional Other Provider) when the Eligible Expense is:
 - a. Individual, group, family, or conjoint psychotherapy,
 - b. Counseling,
 - c. Psychoanalysis,
 - d. Psychological testing and assessment,
 - e. The administration or monitoring of psychotropic drugs, or
 - f. Hospital visits or consultations in a facility listed in subsection 5, below;
3. Electroconvulsive treatment;
4. Psychotropic drugs;
5. Any of the services listed in subsections 1 through 4, above, performed in or by a Hospital, Facility Other Provider, or other licensed facility or unit providing such care.

Morbid Obesity means a Body Mass Index (BMI) of greater than or equal to 40 kg/meter² or a BMI greater than or equal to 35 kg/meters² with at least two of the following co-morbid conditions which have not responded to a maximum medical management and which are generally expected to be reversed or improved by bariatric treatment:

- Hypertension
- Dyslipidemia
- Type 2 diabetes
- Coronary heart disease
- Sleep Apnea

Network means identified Physicians, Behavioral Health Practitioner, Professional Other Providers, Hospitals, and other facilities that have entered into agreements with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) for participation in a managed care arrangement.

Network Provider means a Hospital, Physician, Behavioral Health Practitioner, or Other Provider who has entered into an agreement with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider.

Non-Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution which has not executed a written contract with BCBSTX for the provision of care, services, or supplies for which benefits are provided by the Plan. Any Hospital, Facility Other Provider, facility, or institution with a written contract with BCBSTX which has expired or has been canceled is a Non-Contracting Facility.

Open Enrollment Period means the 31-day period preceding the next Plan Anniversary Date during which Employees and Dependents may enroll for coverage.

Other Provider means a person or entity, other than a Hospital or Physician, that is licensed where required to furnish to a Participant an item of service or supply described herein as Eligible Expenses. Other Provider shall include:

1. **Facility Other Provider** – an institution or entity, only as listed:
 - a. Chemical Dependency Treatment Center
 - b. Crisis Stabilization Unit or Facility
 - c. Durable Medical Equipment Provider
 - d. Home Health Agency
 - e. Home Infusion Therapy Provider
 - f. Hospice
 - g. Imaging Center
 - h. Independent Laboratory
 - i. Prosthetics/Orthotics Provider
 - j. Psychiatric Day Treatment Facility
 - k. Renal Dialysis Center
 - l. Residential Treatment Center for Children and Adolescents
 - m. Skilled Nursing Facility
 - n. Therapeutic Center
2. **Professional Other Provider** – a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:
 - a. Advanced Practice Nurse
 - b. Doctor of Chiropractic
 - c. Doctor of Dentistry
 - d. Doctor of Optometry
 - e. Doctor of Podiatry
 - f. Doctor in Psychology
 - g. Licensed Acupuncturist
 - h. Licensed Audiologist
 - i. Licensed Chemical Dependency Counselor
 - j. Licensed Dietitian
 - k. Licensed Hearing Instrument Fitter and Dispenser
 - l. Licensed Marriage and Family Therapist
 - m. Licensed Clinical Social Worker

- n. Licensed Occupational Therapist
- o. Licensed Physical Therapist
- p. Licensed Professional Counselor
- q. Licensed Speech–Language Pathologist
- r. Licensed Surgical Assistant
- s. Nurse First Assistant
- t. Physician Assistant
- u. Psychological Associates who work under the supervision of a Doctor in Psychology

In states where there is a licensure requirement, other Providers must be licensed by the appropriate state administrative agency.

Out-of-Network Benefits means the benefits available under the Plan for services and supplies that are provided by an Out-of-Network Provider.

Out-of-Network Provider means a Hospital, Physician, Behavioral Health Practitioner, or Other Provider who has not entered into an agreement with BCBSTX (or other participating Blue Cross and/or Blue Shield Plan) as a managed care Provider.

Out-of-Pocket Maximum means, if “Individual only” coverage is elected, the cumulative dollar amount of Eligible Expenses, including the Calendar Year Deductible, incurred by the Employee during a Calendar Year. If “Family” coverage is elected, Out-of-Pocket Maximum means the cumulative dollar amount of Eligible Expenses, including the Calendar Year Deductible, incurred by the family during a Calendar Year.

Outpatient Contraceptive Services means a consultation, examination, procedure, or medical service that is provided on an outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy.

Participant means an Employee or Dependent whose coverage has become effective under this Plan.

Physical Medicine Services means those modalities, procedures, tests, and measurements listed in the *Physicians’ Current Procedural Terminology Manual* (Procedure Codes 97010–97799), whether the service or supply is provided by a Physician or Professional Other Provider, and includes, but is not limited to, physical therapy, occupational therapy, hot or cold packs, whirlpool, diathermy, electrical stimulation, massage, ultrasound, manipulation, muscle or strength testing, and orthotics or prosthetic training.

Physician means a person, when acting within the scope of his license, who is a Doctor of Medicine or Doctor of Osteopathy.

Plan means a program of health and welfare benefits established for the benefit of its Participants whether the plan is subject to the rules and regulations of the Employee’s Retirement and Income Security Act (ERISA) or, for government and/or church plans, where compliance is voluntary.

Plan Administrator means the Group Health Plan (GHP) or a named administrator of the Plan having fiduciary responsibility for its operation. BCBSTX is not the Plan Administrator.

Plan Anniversary Date means the day, month, and year of the 12-month period following the Plan Effective Date and corresponding date in each year thereafter for as long as this Benefit Booklet is in force.

Plan Effective Date means the date on which coverage for the Employer’s Plan begins with the Claim Administrator.

Plan Month means each succeeding calendar month period, beginning on the Plan Effective Date.

Plan Service Area means the geographical area(s) or areas in which a Network of Providers is offered and available and is used to determine eligibility for **Managed Health Care Plan** benefits.

Preauthorization means the process that determines in advance the Medical Necessity or Experimental/Investigational nature of certain care and services under this Plan.

Primary Care Provider means a Physician or Professional Other Provider who has entered into an agreement with Claim Administrator (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider of a family practitioner, obstetrician/gynecologist, pediatrician, Behavioral Health Practitioner, an internist or a Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these.

Proof of Loss means written evidence of a claim including:

1. The form on which the claim is made;
2. Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim, and
3. Correct diagnosis code(s) and procedure code(s) for the services and items.

Prosthetic Appliances means artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). For purposes of this definition, a wig or hairpiece is not considered a Prosthetic Appliance.

Prosthetics/Orthotics Provider means a certified prosthetist that supplies both standard and customized prostheses and orthotic supplies.

Provider means a Hospital, Physician, Behavioral Health Practitioner, Other Provider, or any other person, company, or institution furnishing to a Participant an item of service or supply listed as Eligible Expenses.

Psychiatric Day Treatment Facility means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a Psychiatric Day Treatment Facility for the provision of Mental Health Care and Serious Mental Illness services to Participants for periods of time not to exceed eight hours in any 24-hour period. Any treatment in a Psychiatric Day Treatment Facility must be certified in writing by the attending Physician or Behavioral Health Practitioner to be in lieu of hospitalization.

Renal Dialysis Center means a facility which is Medicare certified as an end-stage renal disease facility providing staff assisted dialysis and training for home and self-dialysis.

Research Institution means an institution or Provider (person or entity) conducting a phase I, phase II, phase III, or phase IV clinical trial.

Residential Treatment Center for Children and Adolescents means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provisions of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

Routine Patient Care Costs means the costs of any Medically Necessary health care service for which benefits are provided under the Plan, without regard to whether the Participant is participating in a clinical trial.

Routine patient care costs do not include:

1. The cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial;
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

4. A cost associated with managing a clinical trial; or
5. The cost of a health care service that is specifically excluded from coverage under the Plan.

Serious Mental Illness means the following psychiatric illnesses defined by the *American Psychiatric Association in the Diagnostic and Statistical Manual (DSM)*:

1. Bipolar disorders (hypomanic, manic, depressive, and mixed);
2. Depression in childhood and adolescence;
3. Major depressive disorders (single episode or recurrent);
4. Obsessive-compulsive disorders;
5. Paranoid and other psychotic disorders;
6. Schizo-affective disorders (bipolar or depressive); and
7. Schizophrenia.

Skilled Nursing Facility means a facility primarily engaged in providing skilled nursing services and other therapeutic services and which is:

1. Licensed in accordance with state law (where the state law provides for licensing of such facility); or
2. Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care.

Specialty Care Provider means a Physician or Professional Other Provider who has entered into an agreement with Claim Administrator (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider of specialty services with the exception of a family practitioner, obstetrician/gynecologist, pediatrician, Behavioral Health Practitioner, an internist or a Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these.

Therapeutic Center means an institution which is appropriately licensed, certified, or approved by the state in which it is located and which is:

1. An ambulatory (day) surgery facility;
2. A freestanding radiation therapy center; or
3. A freestanding birthing center.

Waiting Period means a period established by an Employer that must pass before an individual who is a potential enrollee in a Health Benefit Plan is eligible to be covered for benefits.

GENERAL PROVISIONS

Agent

The Employer is not the agent of the Claim Administrator.

Amendments

The Plan may be amended or changed at any time by agreement between the Employer and the Claim Administrator. No notice to or consent by any Participant is necessary to amend or change the Plan.

Assignment and Payment of Benefits

Rights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided.

In the absence of a written agreement with a Provider, the Claim Administrator reserves the right to make benefit payments to the Provider or the Employee, as the Claim Administrator elects. Payment to either party discharges the Plan's responsibility to the Employee or Dependents for benefits available under the Plan.

Claims Liability

BCBSTX, in its role as Claim Administrator, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Disclosure Authorization

If you file a claim for benefits, it will be necessary that you authorize any health care Provider, insurance carrier, or other entity to furnish the Claim Administrator all information and records or copies of records relating to the diagnosis, treatment, or care of any individual included under your coverage. If you file claims for benefits, you and your Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

Medicare

Special rules apply when you are covered by this Plan and by Medicare. Generally, this Plan is a Primary Plan if you are an active Employee, and Medicare is a Primary Plan if you are a retired Employee.

Participant/Provider Relationship

The choice of a health care Provider should be made solely by you or your Dependents. The Claim Administrator does not furnish services or supplies but only makes payment for Eligible Expenses incurred by Participants. The Claim Administrator is not liable for any act or omission by any health care Provider. The Claim Administrator does not have any responsibility for a health care Provider's failure or refusal to provide services or supplies to you or your Dependents. Care and treatment received are subject to the rules and regulations of the health care Provider selected and are available only for sickness or injury treatment acceptable to the health care Provider.

The Claim Administrator, Network Providers, and/or other contracting Providers are independent contractors with respect to each other. The Claim Administrator in no way controls, influences, or participates in the health care treatment decisions entered into by said Providers. The Claim Administrator does not furnish medical, surgical, hospitalization, or similar services or supplies, or practice medicine or treat patients. The Providers, their employees, their agents, their ostensible agents, and/or their representatives do not act on behalf of BCBSTX nor are they employees of BCBSTX.

Refund of Benefit Payments

If the Claim Administrator pays benefits for Eligible Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error, the Plan has the right to a refund from the

person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, the Claim Administrator may deduct any refund due it from any future benefit payment.

Subrogation

If the Plan pays or provides benefits for you or your Dependents, the Plan is subrogated to all rights of recovery which you or your Dependent have in contract, tort, or otherwise against any person, organization, or insurer for the amount of benefits the Plan has paid or provided. That means the Plan may use your rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer.

For the purposes of this provision, *subrogation* means the substitution of one person or entity (the Plan) in the place of another (you or your Dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

Right of Reimbursement

In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, the Plan will have a right of reimbursement.

If you or your Dependent recover money from any person, organization, or insurer for an injury or condition for which the Plan paid benefits, you or your Dependent agree to reimburse the Plan from the recovered money for the amount of benefits paid or provided by the Plan. That means you or your Dependent will pay to the Plan the amount of money recovered by you through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the Plan.

Right to Recovery by Subrogation or Reimbursement

You or your Dependent agree to promptly furnish to the Plan all information which you have concerning your rights of recovery from any person, organization, or insurer and to fully assist and cooperate with the Plan in protecting and obtaining its reimbursement and subrogation rights. You, your Dependent or your attorney will notify the Plan before settling any claim or suit so as to enable us to enforce our rights by participating in the settlement of the claim or suit. You or your Dependent further agree not to allow the reimbursement and subrogation rights of the Plan to be limited or harmed by any acts or failure to act on your part.

Maintenance of Benefits

The availability of benefits specified in This Plan is subject to Maintenance of Benefits (MOB) as described below. This MOB provision applies to This Plan when a Participant has health care coverage under more than one Plan.

If this MOB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan shall not be reduced when This Plan determines its benefits before another Plan; but may be reduced when another Plan determines its benefits first.

Maintenance of Benefits – Definitions

1. **Plan** means any group insurance or group-type coverage, whether insured or uninsured.

This includes:

- a. group or blanket insurance;
- b. franchise insurance that terminates upon cessation of employment;
- c. group hospital or medical service plans and other group prepayment coverage;
- d. any coverage under labor-management trustee arrangements, union welfare arrangements, or employer organization arrangements;
- e. governmental plans, or coverage required or provided by law.

Plan does *not* include:

- a. any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;
- b. a policy of health insurance that is individually underwritten and individually issued;
- c. school accident type coverage; or
- d. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and MOB rules apply only to one of the two, each of the parts is a separate Plan.

2. **This Plan** means the part of this Benefit Booklet that provides benefits for health care expenses.

3. **Primary Plan/Secondary Plan**

The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the Participant. A *Primary Plan* is a Plan whose benefits are determined before those of the other Plan and without considering the other Plan's benefit. A *Secondary Plan* is a Plan whose benefits are determined after those of a Primary Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the Participant, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

4. **Allowable Expense** means a necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part by This Plan.
5. **We or Us** means Blue Cross and Blue Shield of Texas.

Order of Benefit Determination Rules

1. **General Information**

- a. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless (a) the other Plan has rules that take into consideration the benefits of other plans when determining its benefits, and (b) both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.
- b. If this Benefit Booklet contains any dental or vision benefits, the benefits provided by the health portion of This Plan will be the Secondary Plan.

2. **Rules**

This Plan determines its order of benefits using the first of the following rules which applies:

- a. ***Non-Dependent/Dependent.*** The benefits of the Plan which covers the Participant as an Employee, member or subscriber are determined before those of the Plan which covers the Participant as a Dependent. However, if the Participant is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is

(1) secondary to the Plan covering the Participant as a Dependent and

(2) primary to the Plan covering the Participant as other than a Dependent (e.g., a retired Employee),

then the benefits of the Plan covering the Participant as a Dependent are determined before those of the Plan covering that Participant as other than a Dependent.

- b. ***Dependent Child/Parents Not Separated or Divorced.*** Except as stated in Paragraph c below, when This Plan and another Plan cover the same child as a Dependent of different parents:

- (1) The benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but
- (2) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in this Paragraph b, but instead has a rule based on gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- c. ***Dependent Child/Parents Separated or Divorced.*** If two or more Plans cover a Participant as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

- (1) First, the Plan of the parent with custody of the child;
- (2) Then, the Plan of the spouse of the parent with custody, if applicable;
- (3) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Calendar Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- d. ***Joint Custody.*** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph b.
- e. ***Active/Inactive Employee.*** The benefits of a Plan which covers a Participant as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired Employee. The same would hold true if a Participant is a Dependent of a person covered as a retired Employee and an Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Paragraph e does not apply.
- f. ***Continuation Coverage.*** If a Participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:

- (1) First, the benefits of a Plan covering the Participant as an Employee, member or subscriber (or as that Participant's Dependent);
- (2) Second, the benefits under the continuation coverage.

If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits this Paragraph f does not apply.

- g. ***Longer/Shorter Length of Coverage.*** If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that Participant for the shorter period of time.

Effect on the Benefits of This Plan

1. When This Section Applies

This section applies when This Plan is the Secondary Plan in accordance with the ***Order of Benefits Determination Rules*** outlined above. In that event, the benefits of This Plan may be reduced under this section.

2. Reduction in this Plan's Benefits

When This Plan is the Secondary Plan, This Plan will first calculate its benefit for Allowable Expenses as if it were the Primary Plan, then, if the benefit payable by the Primary Plan for those expenses (whether or not claim is made):

- a. equals or exceeds the benefit that would have been payable by This Plan if it had been the Primary Plan, no benefit will be paid by This Plan; or
- b. is less than the amount of benefit that would have been payable by This Plan if it had been the Primary Plan, the benefit payable by This Plan will be (i) the amount that would have been payable by This Plan if it had been the Primary Plan, reduced by (ii) the amount payable by the Primary Plan.

NOTE: This Maintenance of Benefits provision may result in unreimbursed patient out-of-pocket expenses despite coverage under two or more Plans.

Right to Receive and Release Needed Information

We assume no obligation to discover the existence of another Plan, or the benefits available under the other Plan, if discovered. We have the right to decide what information we need to apply these MOB rules. We may get needed information from or release information to any other organization or person without telling, or getting the consent of, any person. Each person claiming benefits under This Plan must give us any information concerning the existence of other Plans, the benefits thereof, and any other information needed to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again.

Right to Recovery

If the amount of the payments We make is more than We should have paid under this MOB provision, We may recover the excess from one or more of:

1. the persons We have paid or for whom We have paid;
2. insurance companies; or
3. Hospitals, Physicians, or Other Providers; or
4. any other person or organization.

Termination of Coverage

The Claim Administrator for the Plan is not required to give you prior notice of termination of coverage. The Claim Administrator will not always know of the events causing termination until after the events have occurred.

Termination of Individual Coverage

Coverage under the Plan for you and/or your Dependents will automatically terminate when:

1. Your contribution for coverage under the Plan is not received timely by the Plan Administrator; or
2. You no longer satisfy the definition of an Employee as defined in this Benefit Booklet, including termination of employment; or
3. The Plan is terminated or the Plan is amended, at the direction of the Plan Administrator, to terminate the coverage of the class of Employees to which you belong; or
4. A Dependent ceases to be a Dependent as defined in the Plan.

However, when any of these events occur, you and/or your Dependents may be eligible for continued coverage. See **Continuation of Group Coverage – Federal** in the **GENERAL PROVISIONS** section of this Benefit Booklet.

The Claim Administrator may refuse to renew the coverage of an eligible Employee or Dependent for fraud or intentional misrepresentation of a material fact by that individual.

Coverage for a child of any age who is medically certified as *Disabled* and dependent on the parent will not terminate upon reaching the limiting age shown in your Schedule of Coverage if the child continues to be both:

1. *Disabled*, and
2. Dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under the Plan and before the child attains the limiting age. You must submit satisfactory proof of the disability and dependency through your Plan Administrator to the Claim Administrator within 31 days following the child's attainment of the limiting age. As a condition to the continued coverage of a child as a *Disabled* Dependent beyond the limiting age, the Claim Administrator may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Termination of the Group

The coverage of all Participants will terminate if the group is terminated in accordance with the terms of the Plan.

Notice of Creditable Coverage

Upon termination of your coverage under this Plan, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of your or your Dependent's coverage under this Plan.

Continuation of Group Coverage – Federal

COBRA Continuation – Federal

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Participants may have the right to continue coverage after the date coverage ends. Participants will not be eligible for COBRA continuation if the Employer is exempt from the provisions of COBRA.

Please check with your Employer or Human Resources Department to determine if Domestic Partners are eligible for COBRA-like benefits in your Plan. For specific criteria or necessary forms required to establish eligibility for benefit coverage under this Plan, contact your Employer or Human Resources Department.

Minimum Size of Group

The Group must have normally employed more than twenty (20) employees on a typical business day during the preceding Calendar Year. This refers to the number of full-time and part-time employees employed, not the number of employees covered by a Health Benefit Plan.

Loss of Coverage

If coverage terminates as the result of termination (other than for gross misconduct) or reduction of employment hours, then the Participant may elect to continue coverage for eighteen (18) months from the date coverage would otherwise cease.

A covered Dependent may elect to continue coverage for thirty-six (36) months from the date coverage would otherwise cease if coverage terminates as the result of:

1. divorce from the covered Employee,
2. death of the covered Employee,
3. the covered Employee becomes eligible for Medicare, or
4. a covered Dependent child no longer meets the Dependent eligibility requirements.

COBRA continuation under the Plan ends at the earliest of the following events:

1. The last day of the eighteen (18) month period for events which have a maximum continuation period of eighteen (18) months.
2. The last day of the thirty-six (36) month period for events which have a maximum continuation period of thirty-six (36) months.
3. The first day for which timely payment of contribution is not made to the Plan with respect to the qualified beneficiary.
4. The Group Health Plan is canceled.
5. The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other group health plan.
6. The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare benefits.

Extension of Coverage Period

The eighteen (18) month coverage period may be extended if an event which could otherwise qualify a Participant for the thirty-six (36) month coverage period occurs during the eighteen (18) month period, but in no event may coverage be longer than thirty-six (36) months from the initial qualifying event.

If a Participant is determined to be disabled as defined under the Social Security Act and the Participant notifies the Employer before the end of the initial eighteen (18) month period, coverage may be extended up to an additional eleven (11) months for a total of twenty-nine (29) months. This provision is limited to Participants who are disabled at any time during the first sixty (60) days of COBRA continuation and only if the qualifying event is termination of employment (other than for gross misconduct) or reduction of employment hours.

Notice of COBRA Continuation Rights

The Employer is responsible for providing the necessary notification to Participants as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

For additional information regarding your rights under COBRA continuation, refer to the Continuation Coverage Rights Notice in the **NOTICES** section of this Benefit Booklet.

Information Concerning Employee Retirement Income Security Act of 1974 (ERISA)

If the Health Benefit Plan is part of an “employee welfare benefits plan” and “welfare plan” as those terms are defined in ERISA:

1. The Plan Administrator will furnish summary plan descriptions, annual reports, and summary annual reports to you and other plan participants and to the government as required by ERISA and its regulations.
2. The Claim Administrator will furnish the Plan Administrator with this Benefit Booklet as a description of benefits available under this Health Benefit Plan. Upon written request by the Plan Administrator, the Claim

Administrator will send any information which the Claim Administrator has that will aid the Plan Administrator in making its annual reports.

3. Claims for benefits must be made in writing on a timely basis in accordance with the provisions of this Health Benefit Plan. Claim filing and claim review health procedures are found in the **CLAIM FILING AND APPEALS PROCEDURES** section of this Benefit Booklet.
4. BCBSTX, as the Claim Administrator is not the ERISA “Plan Administrator” for benefits or activities pertaining to the Health Benefit Plan.
5. This Benefit Booklet is not a Summary Plan Description.
6. The Plan Administrator has given the Claim Administrator the authority and discretion to interpret the Health Benefit Plan provisions and to make eligibility and benefit determinations. The Plan Administrator has full and complete authority and discretion to make decisions regarding the Health Benefit Plan’s provisions and determining questions of eligibility and benefits. Any decisions made by the Plan Administrator shall be final and conclusive.

AMENDMENTS

NOTICES

NOTICE

Other Blue Cross and Blue Shield Plans Separate Financial Arrangements with Providers

BlueCard

Blue Cross and Blue Shield of Texas hereby informs you that other Blue Cross and Blue Shield Plans outside of Texas (“Host Blues”) may have contracts similar to the contracts described above with certain Providers (“Host Blue Providers”) in their service areas.

When you access health care services through BlueCard outside of Texas and from a Provider which does not have a contract with Blue Cross and Blue Shield of Texas, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your covered services, or
- The negotiated price that the Host Blue passes on to Blue Cross and Blue Shield of Texas.

Often, this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that takes into consideration the actual price increased or reduced to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be charged as a billed charge reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, Blue Cross and Blue Shield of Texas would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

NOTICE

The Women's Health and Cancer Rights Act of 1998 requires this notice. This Act is effective for plan year anniversaries on or after October 21, 1998. This benefit may already be included as part of your coverage.

In the case of a covered person receiving benefits under their plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Deductibles, Co-Share and copayment amounts will be the same as those applied to other similarly covered medical services, such as surgery and prostheses.

NOTICE

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN.

NOTICE**CONTINUATION COVERAGE RIGHTS UNDER COBRA**

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of

COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

Information Provided by your Employer

EMPLOYEE RETIREMENT INCOME
SECURITY ACT OF 1974
PLAN ADMINISTRATION INFORMATION

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your benefit booklet/Certificate. Your Plan Administrator has determined that this information together with the information contained in your benefit booklet/Certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Blue Cross and Blue Shield is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan: Service Experts LLC

Plan Sponsor:

Service Experts LLC
3820 American Drive, Suite 200
Plano, TX 75075-6126

Employer Identification Number: 621639453

Plan Number: 501

Plan Administrator:

Service Experts LLC
3820 American Drive, Suite 200
Plano, TX 75075-6126
Telephone: 972-535-3800

Type of Plan: Service Experts LLC Health and Welfare Plan

Type of Plan Administration: Employer Administered

Claim Administration:

Claims for benefits should be directed to:
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044901

Agent For Service of Legal Process:

Service Experts LLC
3820 American Drive, Suite 200
Plano, TX 75075-6126

Plan Year: January 1, 2014 – December 31, 2014

Waiting Period: The 1st day of the month following 60 days of employment.

Open Enrollment: Fall of each Plan Year

Funding Arrangements: Self-funded

Contributions: Funding is derived from employer and employee contributions. The Plan is not insured.

Eligibility:

An eligible person is one who is regularly scheduled to work a minimum of 30 hours per week and who is on the permanent payroll of the Employer.

Benefits and Administration:

The Plan Sponsor provides certain administrative services in connection with this Plan. The Plan Sponsor has contracted with:

Blue Cross Blue Shield of Texas (BCBSTX)
Claims Division
P.O. Box 660044
Dallas, Texas 75225-0044

Loss of Benefits:

<< >> An explanation of circumstances that may result in disqualification, ineligibility, loss, forfeiture or suspension of any benefits.

Type of Plan:

Health & Welfare Benefit Plan

Termination of Plan or Bankruptcy:

Service Experts LLC
3820 American Drive, Suite 200

Plano, TX 75075-6126
Telephone: 972-535-3800

How To Get Your Benefits:

This information is explained in the section of the booklet entitled “**CLAIMS FILING PROCEDURES.**”

Claim Review Procedure:

This information is explained in the section of the booklet entitled “**REVIEW OF CLAIMS DETERMINATIONS**”

Statement of ERISA Rights:

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

- a. Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- c. Receive a summary of the plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage:

- a. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this booklet and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- b. Reduction or elimination of exclusionary periods of coverage for Preexisting Conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a certificate of Creditable Coverage, free of charge from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation

coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a preexisting exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries:

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit under the plan or exercising your rights under ERISA.

Enforce Your Rights:

If your Claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen the plan fiduciaries misuse the plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees.

If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your Claim is frivolous.

Assistance With Your Questions:

If you have any questions about the plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue, N. W., Washington, D. C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. UNIFORMED

SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA):

Group health plans and health insurance issuers, under USERRA, must protect all persons who perform duty, voluntarily or involuntarily, in the “uniformed services”, which include the Army, Navy, Marine Corps, Air Force, Coast Guard and Public Health Service commissioned corps, as well as the reserve components of each of these services. If you are a pre-service member returning from a period of service in the uniformed services, you are entitled to reemployment from your Employer if you meet the following criteria:

- you held the job prior to service;
- you gave notice to your Employer that you were leaving your employment for service in the uniformed services, unless giving notice was precluded by military necessity or otherwise impossible or unreasonable;
- your cumulative period of service did not exceed five years;
- you were not released from service under dishonorable or other punitive conditions; and
- you reported back to the job in a timely manner or submitted a timely application for reemployment.

The time limits for returning to work are as follows:

- For less than 31 days of service – by the beginning of the first regularly scheduled work period after the end of the calendar day of duty, plus time required to return home safely and an eight hour rest period. If this is impossible or unreasonable through no fault of your own, then as soon as possible;
- For 31 to 180 days of service – you must apply for reemployment no later than 14 days after completion of military service. If this is impossible or unreasonable through no fault of your own, then as soon as possible;
- For 181 days or more of service – you must apply for reemployment no later than 90 days after completion of military service;
- For service-connected injury or illness – reporting or application deadlines are extended for up to two years if you are hospitalized or convalescing.

Important Notice:

To obtain information or make a complaint you may call Blue Cross and Blue Shield of Texas's toll-free telephone number for information or to make a complaint at: 1-800-521-2227. You may also write to Blue Cross and Blue Shield of Texas at: P.O. Box 660044, Dallas, Texas 75266-0044

Aviso Importante:

Para obtener informacion o para someter una queja usted puede llamar al numero de telefono gratis de Blue Cross and Blue Shield of Texas para informacion o para someter una queja al: 1-800-521-2227. Usted tambien puede escribir a Blue Cross and Blue Shield of Texas al: P. O. Box 660044, Dallas, Texas 75266-0044.

Administered by:



BlueCross BlueShield of Texas



bcbstx.com

EXHIBIT B

Your Health Care Benefits Program



Patterson-UTL Energy, Inc.

Group #034407

Managed Health Care (PPO)
Pharmacy Benefits

Administered by:



BlueCross BlueShield of Texas

January 1, 2014

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SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles		
<ul style="list-style-type: none"> Per-admission Deductible Calendar Year Deductible <i>Three-month Deductible carryover applies</i> 	\$250 per-admission Deductible \$500 – per individual \$1,500 – per family	\$250 per-admission Deductible \$2,000 – per individual \$4,000 – per family
Co-Share Stop-Loss Amounts	\$2,500 – per individual \$7,500 – per family	\$5,000 – per individual \$10,000 – per family
Copayment Amounts Required		
<ul style="list-style-type: none"> Physician office visit/consultation 	\$30 Physician office visit	Does Not Apply
Inpatient Hospital Expenses		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	80% of Allowable Amount after \$250 per-admission Deductible No penalty for failure to Preauthorize services	60% of Allowable Amount after \$250 per-admission Deductible \$250 penalty for failure to Preauthorize services
Medical-Surgical Expenses		
<ul style="list-style-type: none"> Office visit/consultation including lab and x-rays Inpatient visits Certain Diagnostic Procedures Home Infusion Therapy Physician surgical services in any setting Allergy Injections (without office visit) Independent lab and x-ray 	100% of Allowable Amount after \$30 Copayment Amount 80% of Allowable Amount after Calendar Year Deductible 100% of Allowable Amount	60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible
Extended Care Expenses	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> Skilled Nursing Facility 	25 maximum combined days per Calendar Year	
<ul style="list-style-type: none"> Home Health Care 	60 maximum combined visits per Calendar Year	
<ul style="list-style-type: none"> Hospice Care 	No Limit	

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SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Mental Health Care, Serious Mental Illness, and Treatment of Chemical Dependency Inpatient Services <ul style="list-style-type: none"> Hospital services (facility) Behavioral Health Practitioner services Outpatient Services <ul style="list-style-type: none"> Behavioral Health Practitioner expenses (office setting) Other outpatient services 	80% of Allowable Amount after \$250 per-admission Deductible 80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after \$250 per-admission Deductible 60% of Allowable Amount after Calendar Year Deductible
Emergency Care Accidental Injury and Emergency Care (including Accidental Injury and Emergency Care for Behavioral Health Services) <ul style="list-style-type: none"> Facility Charges Physician Charges Non-Emergency Care (including Non-Emergency Care for Behavioral Health Services) <ul style="list-style-type: none"> Facility Charges Physician Charges 	80% of Allowable Amount after Calendar Year Deductible 80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible
Ambulance Services	80% of Allowable Amount after Calendar Year Deductible	
Preventive Care <ul style="list-style-type: none"> Routine physical examinations Well baby care Immunizations, 6 years and over Vision and hearing examinations Independent lab and x-ray (includes outpatient Facilities) Immunizations, birth up to age 6 	100% of Allowable Amount 100% of Allowable Amount 100% of Allowable Amount	60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible 100% of Allowable Amount

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Speech and Hearing Services, including hearing aids <ul style="list-style-type: none"> Office visit All other services 	100% of Allowable Amount after \$30 Copayment Amount 80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible
	Limited to one per ear per 36-month period for hearing aids	
Chiropractic Services <ul style="list-style-type: none"> Office visit All other services 	100% of Allowable Amount after \$30 Copayment Amount 80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible
	35 maximum combined visits per Calendar Year	
Physical Medicine Services <ul style="list-style-type: none"> Office visit/office services All other outpatient services 	100% of Allowable Amount after \$30 Copayment Amount 80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible
Vision Care <ul style="list-style-type: none"> Conventional lenses Contact lenses 	80% of Allowable Amount up to \$200 maximum benefit per Calendar Year	

SCHEDULE OF COVERAGE**PHARMACY BENEFITS**

Plan Provisions	Participating Pharmacy	Non-Participating Pharmacy
Retail Pharmacy, up to a 90-day supply with one Copayment Amount every 30 days	\$15 Copayment Amount Generic Drugs \$40 Copayment Amount* Preferred Brand Name Drugs \$60 Copayment Amount* Non-Preferred Brand Name Drugs	70% of Allowable Amount minus Copayment Amount
Mail-Order Program, up to a 90-day supply with one Copayment Amount every 90 days	\$30 Copayment Amount Generic Drugs \$80 Copayment Amount* Preferred Brand Name Drugs \$120 Copayment Amount* Non-Preferred Brand Name Drugs	
Specialty Drugs, 30-day supply	\$120 Copayment Amount	
Limitations on Quantities Dispensed	Applies	
Diabetes Supplies are available under the Pharmacy Benefits portion of your Plan. All provisions of this portion of the Plan will apply including any Copayment Amounts, Co-Share Amounts, and any additional costs.		

* If you receive a Preferred Brand Name Drug or a Non-Preferred Brand Name Drug when a Generic Drug is available, you may incur additional costs. Refer to the Pharmacy Benefits portion of this Benefit Booklet for details.

Dependent Eligibility

Dependent Child Age Limit to age 26.

Dependent children are eligible for Maternity Care benefits.

Preexisting Conditions

Preexisting conditions are covered immediately.

INTRODUCTION

This Plan is offered by your Employer as one of the benefits of your employment. The benefits provided are intended to assist you with many of your health care expenses for Medically Necessary services and supplies. Coverage under this Plan is provided regardless of your race, color, national origin, disability, age, sex, gender identity, or sexual orientation. There are provisions throughout this Benefit Booklet that affect your health care coverage. It is important that you read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan. In the event of any conflict between any components of this Plan, the Administrative Services Agreement provided to your Employer by Blue Cross and Blue Shield of Texas (BCBSTX) prevails.

The defined terms in this Benefit Booklet are capitalized and shown in the appropriate provision in the Benefit Booklet or in the **DEFINITIONS** section of the Benefit Booklet. Whenever these terms are used, the meaning is consistent with the definition given. Terms in italics may be section headings describing provisions or they may be defined terms.

The terms “you” and “your” as used in this Benefit Booklet refer to the Employee. Use of the masculine pronoun “his,” “he,” or “him” will be considered to include the feminine unless the context clearly indicates otherwise.

Managed Health Care – In–Network Benefits

To receive In–Network Benefits as indicated on your Schedule of Coverage, **you must** choose Providers within the Network for all care (**other than for emergencies**). The Network has been established by BCBSTX and consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Participants throughout the Network Plan Service Area. Refer to your Provider directory or visit the BCBSTX website at www.bcbstx.com to make your selections. The listing may change occasionally, so make sure the Providers you select are still Network Providers. An updated directory will be available at least annually. You may access our website, www.bcbstx.com, for the most current listing to assist you in locating a Provider.

To receive In–Network Benefits for Mental Health Care, Serious Mental Illness, and treatment of Chemical Dependency all care should be Preauthorized by calling the toll-free Mental Health Helpline indicated on your Identification Card and in this Benefit Booklet. Services and supplies for Mental Health Care, Serious Mental Illness, and treatment of Chemical Dependency must be provided by Network Providers that have specifically contracted with the Claims Administrator to furnish services and supplies for those types of conditions to be considered for In–Network Benefits.

If you choose a Network Provider, the Provider will bill the Claims Administrator – not you – for services provided.

The Provider has agreed to accept as payment in full the least of...

- The billed charges,
- The Allowable Amount as determined by the Claims Administrator, or
- Other contractually determined payment amounts.

You are responsible for paying any Deductibles, Copayment Amounts, and Co–Share Amounts. You may be required to pay for limited or non–covered services. No claim forms are required.

Managed Health Care – Out–of–Network Benefits

If you choose Out–of–Network Providers, only Out–of–Network Benefits will be available. If you go to a Provider outside the Network, benefits will be paid at the Out–of–Network Benefits level. If you choose a health care Provider outside the Network, you may have to submit claims for the services provided.

You will be responsible for paying...

- Billed charges above the Allowable Amount as determined by the Claims Administrator;
- Co–Share Amounts, Copayment Amounts, and Deductibles;
- Limited or non–covered services; and
- Failure to Preauthorize penalty.

Pharmacy Benefits

Benefits are provided for those Covered Drugs as explained in the **PHARMACY BENEFITS** section and shown on your Schedule of Coverage in this Benefit Booklet. The amount of your payment under the Plan depends on whether:

- the Prescription Order is filled at a Participating Pharmacy, or at a non-Participating Pharmacy, or through the Mail-Order Program;
- a Generic Drug is dispensed;
- a Preferred or Non-Preferred Brand Name Drug is dispensed; or
- a Specialty Drug is dispensed.

Important Contact Information

Resource	Contact Information	Accessible Hours
Customer Service Helpline	1-877-208-5301	Monday – Friday 8:00 a.m. – 8:00 p.m. Central Time
Website	www.bcbstx.com	24 hours a day 7 days a week
Medical Preauthorization Helpline	1-800-441-9188	Monday – Friday 7:30 a.m. – 6:00 p.m. Central Time
Mental Health/Chemical Dependency Preauthorization Helpline	1-800-528-7264	24 hours a day 7 days a week

Customer Service Helpline

Customer Service Representatives can...

- Identify your Plan Service Area,
- Give you information about Network and *ParPlan* and other Providers contracting with BCBSTX,
- Order additional or replacement Identification Cards,
- Distribute claim forms,
- Answer your questions on claims,
- Assist you in identifying a Network Provider (but will not recommend specific Network Providers),
- Provide information on the features of the Plan,
- Record comments about Providers, and
- Assist you with questions regarding the **PHARMACY BENEFITS**.

BCBSTX Website

Visit the BCBSTX website at www.bcbstx.com for information about BCBSTX, access to forms referenced in this Benefit Booklet, and much more.

Medical Preauthorization Helpline

To satisfy all medical Preauthorization requirements for inpatient Hospital Admissions, Extended Care Expenses, or Home Infusion Therapy, call the Medical Preauthorization Helpline.

Mental Health/Chemical Dependency Preauthorization Helpline

To satisfy Preauthorization requirements for Participants seeking treatment for Mental Health Care, Serious Mental Illness, and Chemical Dependency, you, your Physician, Behavioral Health Practitioner, or a family member may call the Mental Health/Chemical Dependency Preauthorization Helpline at any time, day or night.

WHO GETS BENEFITS

Eligibility Requirements for Coverage

The Eligibility Date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when he becomes an Employee or a Dependent and is in a class eligible to be covered under the Plan. The Eligibility Date is:

1. The date the Employee, including any Dependents to be covered, completes the Waiting Period, if any, for coverage;
2. Described in the ***Dependent Enrollment Period*** section for a new Dependent of an Employee already having coverage under the Plan.

No eligibility rules or variations in rate will be imposed on your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of your race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Variations in the administration, processes, or benefits of this Plan that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives, and/or other programs, do not constitute discrimination.

Employee Eligibility

Any person eligible under this Plan and covered by the Employer's previous Health Benefit Plan on the date prior to the Plan Effective Date, including any person who has continued group coverage under applicable federal or state law, is eligible on the Plan Effective Date. Otherwise, you are eligible for coverage under the Plan when you satisfy the definition of an Employee and you reside or work in the Plan Service Area.

Dependent Eligibility

If you apply for coverage, you may include your Dependents. Eligible Dependents are:

1. Your spouse (spouses who are eligible for medical coverage through his/her employer are not eligible for medical coverage under this Plan);
2. A child under the limiting age shown in your Schedule of Coverage;
3. A child of your child who is your Dependent for federal income tax purposes at the time application for coverage of the child is made;
4. Any other child included as an eligible Dependent under the Plan.

A detailed description of Dependent is in the **DEFINITIONS** section of this Benefit Booklet. An Employee must be covered first in order to cover his eligible Dependents. No Dependent shall be covered hereunder prior to the Employee's Effective Date. If you are married to another Employee, you may not cover your spouse as a Dependent, and only one of you may cover any Dependent children.

Effective Dates of Coverage

In order for an Employee's coverage to take effect, the Employee must submit written enrollment for coverage for himself and any Dependents. The Effective Date is the date the coverage for a Participant actually begins. The Effective Date under the Plan is shown on your Identification Card. It may be different from the Eligibility Date.

Timely Applications

It is important that your application for coverage under the Plan is received timely by the Claims Administrator through the Plan Administrator.

If you apply for coverage and make the required contributions for yourself or for yourself and your eligible Dependents and if you:

1. Are eligible on the Plan Effective Date and the application is received by the Claims Administrator through the Plan Administrator prior to or within 31 days following such date, your coverage will become effective on the Plan Effective Date;

2. Enroll for coverage for yourself or for yourself and your Dependents during an Open Enrollment Period, coverage shall become effective on the Plan Anniversary Date; or
3. Become eligible after the Plan Effective Date and if the application is received by the Claims Administrator through the Plan Administrator within the first 31 days following your Eligibility Date, the coverage will become effective in accordance with eligibility information provided by your Employer.

Effective Dates - Delay of Benefits Provided

Coverage becomes effective for you and/or your Dependents on the Plan Effective Date upon completion of an application for coverage. If you or your eligible Dependent(s) are confined in a Hospital or Facility Other Provider on the Plan Effective Date, your coverage is effective on the Plan Effective Date. However, if this Plan is replacing a discontinued Health Benefit Plan or self-funded Health Benefit Plan, benefits for any Employee or Dependent may be delayed until the expiration of any applicable extension of benefits provided by the previous Health Benefit Plan or self-funded Health Benefit Plan.

Effective Dates - Late Enrollee

If your application is not received within 31 days from the Eligibility Date, you will be considered a Late Enrollee. You will become eligible to apply for coverage during your Employer's next Open Enrollment Period. Your coverage will become effective on the Plan Anniversary Date.

Loss of Other Health Insurance Coverage

An Employee who is eligible, but not enrolled for coverage under the terms of the Plan (and/or a Dependent, if the Dependent is eligible, but not enrolled for coverage under such terms) shall become eligible to apply for coverage if each of the following conditions is met:

1. The Employee or Dependent was covered under a Health Benefit Plan, self-funded Health Benefit Plan, or had other health insurance coverage at the time this coverage was previously offered; and
2. Coverage was declined under this Plan in writing, on the basis of coverage under another Health Benefit Plan or self-funded Health Benefit Plan; and
3. There is a loss of coverage under such prior Health Benefit Plan or self-funded Health Benefit Plan as a result of:
 - a. Exhaustion of continuation under Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended; or
 - b. Cessation of Dependent status (such as divorce or attaining the maximum age to be eligible as a dependent child under the Plan), termination of employment, a reduction in the number of hours of employment, or employer contributions toward such coverage were terminated; or
 - c. Termination of the other plan's coverage, a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits, a situation in which the other plan no longer offers any benefits to the class of similarly situated individuals that include you or your Dependent, or, in the case of coverage offered through an HMO, you or your Dependent no longer reside, live, or work in the service area of that HMO and no other benefit option is available; and
4. You request to enroll no later than 31 days after the date coverage ends under the prior Health Benefit Plan or self-funded Health Benefit Plan or, in the event of the attainment of a lifetime limit on all benefits, the request to enroll is made not later than 31 days after a claim is denied due to the attainment of a lifetime limit on all benefits. Coverage will become effective the first day of the Plan Month following receipt of the application by the Claims Administrator through the Plan Administrator.

If all conditions described above are not met, you will be considered a Late Enrollee.

Loss of Governmental Coverage

An individual who is eligible to enroll and who has lost coverage under Medicaid (Title XIX of the Social Security Act), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s) or under the Children's Health Insurance Program (CHIP), Chapter 62, Health and Safety Code, is not a Late Enrollee provided appropriate enrollment application/change forms and applicable contributions are received by the Claims Administrator within sixty (60) days after the date on which such individual loses coverage. Coverage will be effective the day after prior coverage terminated.

Health Insurance Premium Payment (HIPP) Reimbursement Program

An individual who is eligible to enroll and who is a recipient of medical assistance under the Medicaid Program or enrolled in CHIP, and who is a participant in the HIPP Reimbursement Program may enroll with no enrollment period restrictions. If the individual is not eligible unless a family member is enrolled, both the individual and family member may enroll. The Effective Date of Coverage is on the first day of the month after the Claims Administrator receives (i) written notice from the Texas Health and Human Services Commission, or (ii) enrollment forms, from you, provided such forms and applicable contributions are received by the Claims Administrator within sixty (60) days after the date the individual becomes eligible for participation in the HIPP Reimbursement Program.

Dependent Enrollment Period

1. Special Enrollment Period for Newborn Children

Coverage of a newborn child will be automatic for the first 31 days following the birth of your newborn child. For coverage to continue beyond this time, you must notify the Claims Administrator through the Plan Administrator within 31 days of birth and pay any required contributions within that 31-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of birth. If the Claims Administrator is notified through the Plan Administrator after that 31-day period, the newborn child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period.

2. Special Enrollment Period for Adopted Children or Children Involved in a Suit for Adoption

Coverage of an adopted child or child involved in a suit for adoption will be automatic for the first 31 days following the adoption or date on which a suit for adoption is sought. For coverage to continue beyond this time, the Claims Administrator through the Plan Administrator must receive all necessary forms and the required contributions within the 31-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of adoption or date on which a suit for adoption is sought. If you notify the Claims Administrator through the Plan Administrator after that 31-day period, the child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period.

3. Court Ordered Dependent Children

If a court has ordered an Employee to provide coverage for a child, coverage will be automatic for the first 31 days after the date your Employer receives notification of the court order. To continue coverage beyond the 31 days, the Claims Administrator through the Plan Administrator must receive all necessary forms and the required contributions within the 31-day period. If you notify the Claims Administrator through the Plan Administrator after that 31-day period, the Dependent child's coverage will become effective on the Plan Anniversary Date following your Employer's next Open Enrollment Period.

4. Other Dependents

Written application must be received within 31 days of the date that a spouse or child first qualifies as a Dependent. If the written application is received within 31 days, coverage will become effective on the date the child or spouse first becomes an eligible Dependent. If application is not made within the initial 31 days, then your Dependent's coverage will become effective on the Plan Anniversary Date following your Employer's next Open Enrollment Period.

If you ask that your Dependent be provided health care coverage after having canceled his or her coverage while your Dependent was still entitled to coverage, your Dependent's coverage will become effective in accordance with the provisions of the Plan.

In no event will your Dependent's coverage become effective prior to your Effective Date.

Other Employee Enrollment Period

1. As a special enrollment period event, if you acquire a Dependent through birth, adoption, or through suit for adoption, and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage***, as described above, you may apply for coverage for yourself, your spouse, and a newborn child, adopted child, or child involved in a suit for adoption. If the written application is received within 31 days of the birth, adoption, or suit for adoption, coverage for the child, you, or your spouse will become effective on the date of the birth, adoption, or date suit for adoption is sought.

If you marry and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage*** as described above, you may apply for coverage for yourself and your spouse. If the written application is received within 31 days of the marriage, coverage for you and your spouse will become effective on the first day of the month following receipt of the application by the Claims Administrator through the Plan Administrator.

2. If you are required to provide coverage for a child as described in ***Court Ordered Dependent Children*** above, and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage***, you may apply for coverage for yourself. If the written application is received within 31 days of the date your Employer receives notification of the court order, coverage for you will become effective on the date your Employer receives notification of the court order.

Group Enrollment Application/Change Form

Use this form to...

- Notify the Plan of a change to your name,
- Add Dependents,
- Drop Dependents,
- Cancel all or a portion of your coverage, and
- Notify the Plan of all changes in address for yourself and your Dependents.

Changes In Your Family

You should promptly notify the Plan Administrator in the event of a birth or follow the instructions below when events, such as but not limited to, the following take place:

- If you are adding a Dependent due to marriage, adoption, or a child being involved in a suit for which an adoption of the child is sought, or your Employer receives a court order to provide health coverage for a Participant's child or your spouse, you must submit a ***Group Enrollment Application/Change Form*** and the coverage of the Dependent will become effective as described in ***Dependent Enrollment Period***.
- When you divorce, your child reaches the age indicated on your Schedule of Coverage as "Dependent Child Age Limit," or a Participant in your family dies, coverage under the Plan terminates in accordance with the **Termination of Coverage** provisions selected by your Employer.

Notify your Employer promptly if any of these events occur. Benefits for expenses incurred after termination are not available. If your Dependent's coverage is terminated, refund of contributions will not be made for any period before the date of notification. If benefits are paid prior to notification to the Claims Administrator by the Plan Administrator, refunds will be requested.

Please refer to the **Continuation of Group Coverage – Federal** subsection in this Benefit Booklet for additional information.

HOW THE PLAN WORKS

Allowable Amount

The Allowable Amount is the maximum amount of benefits the Claims Administrator will pay for Eligible Expenses you incur under the Plan. The Claims Administrator has established an Allowable Amount for Medically Necessary services, supplies, and procedures provided by Providers that have contracted with the Claims Administrator or any other Blue Cross and/or Blue Shield Plan, and Providers that have not contracted with the Claims Administrator or any other Blue Cross and/or Blue Shield Plan. When you choose to receive services, supplies, or care from a Provider that does not contract with the Claims Administrator, you will be responsible for any difference between the Claims Administrator's Allowable Amount and the amount charged by the non-contracting Provider. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan, any applicable Deductibles, Co-Share Amounts, and Copayment Amounts.

Review the definition of Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet to understand the guidelines used by the Claims Administrator.

Case Management

Under certain circumstances, the Plan allows the Claims Administrator the flexibility to offer benefits for expenses which are not otherwise Eligible Expenses. The Claims Administrator, at its sole discretion, may offer such benefits if:

- The Participant, his family, and the Physician agree;
- Benefits are cost effective; and
- The Claims Administrator anticipates future expenditures for Eligible Expenses which may be reduced by such benefits.

Any decision by the Claims Administrator to provide such benefits shall be made on a case-by-case basis. The case coordinator for the Claims Administrator will initiate case management in appropriate situations.

Freedom of Choice

<i>Each time you need medical care, you can choose to:</i>		
See a Network Provider	See an Out-of-Network Provider	
	ParPlan Provider <i>(refer to ParPlan, below, for more information)</i>	Out-of-Network Provider <i>(not a contracting Provider)</i>
<ul style="list-style-type: none"> • You receive the higher level of benefits (In-Network Benefits) • You are not required to file claim forms • You are not balance billed; Network Providers will not bill for costs exceeding the Claims Administrator's Allowable Amount for covered services • Your Provider will Preauthorize necessary services 	<ul style="list-style-type: none"> • You receive the lower level of benefits (Out-of-Network Benefits) • You are not required to file claim forms in most cases; <i>ParPlan</i> Providers will usually file claims for you • You are not balance billed; <i>ParPlan</i> Providers will not bill for costs exceeding the Claims Administrator's Allowable Amount for covered services • In most cases, <i>ParPlan</i> Providers will Preauthorize necessary services 	<ul style="list-style-type: none"> • You receive Out-of-Network Benefits (the lower level of benefits) • You are required to file your own claim forms • You may be billed for charges exceeding the Claims Administrator's Allowable Amount for covered services • You must Preauthorize necessary services

Identification Card

The Identification Card tells Providers that you are entitled to benefits under your Employer's Health Benefit Plan. The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

- ***Your Subscriber identification number.*** This unique identification number is preceded by a three character alpha prefix that identifies Blue Cross and Blue Shield of Texas as your Claims Administrator.
- ***Your group number.*** This is the number assigned to identify your Employer's Health Benefit Plan with the Claims Administrator.
- ***Any Copayment Amounts that may apply to your coverage.***
- ***Important telephone numbers.***

Always remember to carry your Identification Card with you and present it to your Providers or Participating Pharmacies when receiving health care services or supplies.

Please remember that any time a change in your family takes place it may be necessary for a new Identification Card to be issued to you (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, the Claims Administrator will provide a new Identification Card.

Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards

1. The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you and your covered Dependents will include, but not be limited to, the following actions, when intentional:
 - a. Use of the Identification Card prior to your Effective Date;
 - b. Use of the Identification Card after your date of termination of coverage under the Plan;
 - c. Obtaining prescription drugs or other benefits for persons not covered under the Plan;
 - d. Obtaining prescription drugs or other benefits that are not covered under the Plan;
 - e. Obtaining Covered Drugs for resale or for use by any person other than the person for whom the Prescription Order is written, even though the person is otherwise covered under the Plan;
 - f. Obtaining Covered Drugs without a Prescription Order or through the use of a forged or altered Prescription Order;
 - g. Obtaining quantities of prescription drugs in excess of Medically Necessary or prudent standards of use or in circumvention of the quantity limitations of the Plan;
 - h. Obtaining prescription drugs using Prescription Orders for the same drugs from multiple Providers;
 - i. Obtaining prescription drugs from multiple Pharmacies through use of the same Prescription Order.
2. The fraudulent or intentionally unauthorized, abusive, or other improper use of Identification Cards by any Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under your coverage:
 - a. Denial of benefits;
 - b. Cancellation of coverage under the Plan for **all** Participants under your coverage;
 - c. Limitation on the use of the Identification Card to one designated Physician, Other Provider, or Participating Pharmacy of your choice;
 - d. Recoupment from you or any of your covered Dependents of any benefit payments made;
 - e. Pre-approval of drug purchases and medical services for all Participants receiving benefits under your coverage;
 - f. Notice to proper authorities of potential violations of law or professional ethics.

Medical Necessity

All services and supplies for which benefits are available under the Plan must be Medically Necessary as determined by the Claims Administrator. Charges for services and supplies which the Claims Administrator determines are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy Deductibles or to apply to the Co-Share Stop-Loss Amount.

ParPlan

When you consult a Physician or Professional Other Provider who does not participate in the Network, you should inquire if he participates in the Claims Administrator's *ParPlan*...a simple direct-payment arrangement. If the Physician or Professional Other Provider participates in the *ParPlan*, he agrees to:

- File all claims for you,
- Accept the Claim Administrator's Allowable Amount determination as payment for Medically Necessary services, and
- Not bill you for services over the Allowable Amount determination.

You will receive Out-of-Network Benefits and be responsible for:

- Any Deductibles,
- Copayment Amounts,
- Co-Share Amounts, and
- Services that are limited or not covered under the Plan.

NOTE: If you have a question regarding a Physician's or Professional Other Provider's participation in the *ParPlan*, please contact the Claims Administrator's Customer Service Helpline.

Preexisting Conditions Provision

Benefits for Eligible Expenses incurred for treatment of a preexisting condition will be available immediately with no preexisting condition Waiting Period.

Specialty Care Providers

A wide range of Specialty Care Providers is included in the Network. When you need a specialist's care, In-Network Benefits will be available, but only if you use a Network Provider.

There may be occasions however, when you need the services of an Out-of-Network Provider. This could occur if you have a complex medical problem that cannot be taken care of by a Network Provider.

- If the services you require are not available from Network Providers, In-Network Benefits will be provided when you use Out-of-Network Providers.
- If you elect to see an Out-of-Network Provider and if the services could have been provided by a Network Provider, only Out-of-Network Benefits will be available.

Use of Non-Contracting Providers

When you choose to receive services, supplies, or care from a Provider that does not contract with BCBSTX (a non-contracting Provider), you receive Out-of-Network Benefits (the lower level of benefits). Benefits for covered services will be reimbursed based on the BCBSTX non-contracting Allowable Amount, which in most cases is less than the Allowable Amount applicable for BCBSTX contracted Providers. Please see the definition of non-contracting Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet. **The non-contracted Provider is not required to accept the BCBSTX non-contracting Allowable Amount as payment in full and may balance bill you for the difference between the BCBSTX non-contracting Allowable Amount and the non-contracting Provider's billed charges. You will be responsible for this balance bill amount, which may be considerable.** You will also be responsible for charges for services, supplies and procedures limited or not covered under the Plan and any applicable Deductibles, Co-Share Amounts, and Copayment Amounts.

PRAUTHORIZATION REQUIREMENTS

Preauthorization Requirements

Preauthorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the Preauthorized care and services described below will not be denied on the basis of Medical Necessity or Experimental/Investigational. However, Preauthorization does not guarantee payment of benefits.

Coverage is always subject to other requirements of the Plan, such as limitations and exclusions, payment of contributions, and eligibility at the time care and services are provided.

The following types of services require Preauthorization:

- All inpatient Hospital Admissions,
- Extended Care Expenses,
- Home Infusion Therapy,
- All inpatient treatment of Chemical Dependency,
- All inpatient treatment of Mental Health Care,
- All inpatient treatment of Serious Mental Illness,
- If you transfer to another facility or to or from a specialty unit within the facility, and
- The following outpatient treatment of Chemical Dependency, and Serious Mental Illness and Mental Health Care:
 - Psychological testing,
 - Neuropsychological testing,
 - Electroconvulsive therapy, and
 - Intensive Outpatient Program.

Intensive Outpatient Program means a freestanding or Hospital-based program that provides services for at least three hours per day, two or more days per week, to treat mental illness, drug addiction, substance abuse or alcoholism, or specializes in the treatment of co-occurring mental illness with drug addiction, substance abuse or alcoholism. These programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions which make it unlikely that the Participants will benefit from programs that focus solely on mental illness conditions.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. In-Network Providers will preauthorize services for you, when required.

If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid.

However, if care is not available from Network Providers as determined by the Claim Administrator, and the Claim Administrator acknowledges your visit to an Out-of-Network Provider **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjusted, if appropriate.

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Physician, Behavioral Health Practitioner or Provider of services must comply with the guidelines below. Failure to Preauthorize services will require additional steps and/or benefit reductions as described in the section entitled *Failure to Preauthorize*.

Preauthorization for Inpatient Hospital Admissions

In the case of an elective inpatient Hospital Admission, the call for Preauthorization should be made at least two working days before you are admitted unless it would delay Emergency Care. In an emergency, Preauthorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

To satisfy Preauthorization requirements, on business days between 7:30 a.m. and 6:00 p.m. Central Time, you, your Physician, Provider of services, or a family member should call one of the Customer Service toll-free numbers listed on the back of your Identification Card. After working hours or on weekends, please call the **Medical Preauthorization Helpline** toll-free number listed on the back of your Identification Card. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid. In-Network and Out-of-Network Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

However, if care is not available from Network Providers as determined by BCBSTX, and BCBSTX authorizes your visit to an Out-of-Network Provider to be covered at the In-Network Benefit level **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid.

When an inpatient Hospital Admission is Preauthorized, a length-of-stay is assigned. If you require a longer stay than was first Preauthorized, your Provider may seek an extension for the additional days. Benefits will not be available for room and board charges for medically unnecessary days.

Preauthorization not Required for Maternity Care and Treatment of Breast Cancer Unless Extension of Minimum Length of Stay Requested

Your Plan is required to provide a minimum length-of-stay in a Hospital facility for the following:

- Maternity Care
 - 48 hours following an uncomplicated vaginal delivery
 - 96 hours following an uncomplicated delivery by caesarean section
- Treatment of Breast Cancer
 - 48 hours following a mastectomy
 - 24 hours following a lymph node dissection

You or your Provider will not be required to obtain Preauthorization from BCBSTX for a length of stay less than 48 hours (or 96 hours) for Maternity Care or less than 48 hours (or 24 hours) for Treatment of Breast Cancer. If you require a longer stay, you or your Provider must seek an extension for the additional days by obtaining Preauthorization from BCBSTX.

Preauthorization for Extended Care Expenses and Home Infusion Therapy

Preauthorization for Extended Care Expenses and Home Infusion Therapy may be obtained by having the agency or facility providing the services contact the Claim Administrator to request Preauthorization. The request should be made:

- Prior to initiating Extended Care Expenses or Home Infusion Therapy;
- When an extension of the initially Preauthorized service is required; and
- When the treatment plan is altered.

The Claim Administrator will review the information submitted prior to the start of Extended Care Expenses or Home Infusion Therapy and will send a letter to you and the agency or facility confirming Preauthorization or denying benefits. If Extended Care Expenses or Home Infusion Therapy is to take place in less than one week, the agency or facility should call the Claim Administrator's **Medical Preauthorization Helpline** telephone number indicated in this Benefit Booklet or shown on your Identification Card.

If the Claim Administrator has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

Preauthorization for Mental Health Care, Serious Mental Illness, and Treatment of Chemical Dependency

In order to receive maximum benefits, all inpatient treatment for Mental Health Care, Serious Mental Illness, and Chemical Dependency must be Preauthorized by the Plan. Preauthorization is also required for certain outpatient services. Outpatient services requiring Preauthorization include psychological testing, neuropsychological testing, Intensive Outpatient Programs and electroconvulsive therapy. Preauthorization is not required for therapy visits to a Physician, Behavioral Health Practitioner and/or Professional Other Provider..

To satisfy Preauthorization requirements, you, a family member or your Behavioral Health Practitioner must call the **Mental Health/Chemical Dependency Preauthorization Helpline** toll-free number indicated in this Benefit Booklet or shown on your Identification Card. The **Mental Health/Chemical Dependency Preauthorization Helpline** is available 24 hours a day, 7 days a week. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid. In-Network and Out-of-Network Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

However, if care is not available from Network Providers as determined by BCBSTX, and BCBSTX authorizes your visit to an Out-of-Network Provider to be covered at the In-Network Benefit level **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid.

When a treatment or service is Preauthorized, a length of stay or length of service is assigned. If you require a longer stay or length of service than was first Preauthorized, your Behavioral Health Practitioner may seek an extension for the additional days or visits. Benefits will not be available for medically unnecessary treatments or services.

Failure to Preauthorize

If Preauthorization for inpatient Hospital Admissions, Extended Care Expense, Home Infusion Therapy, all inpatient and the above specified outpatient treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Chemical Dependency is not obtained:

- BCBSTX will review the Medical Necessity of your treatment or service prior to the final benefit determination.
- If BCBSTX determines the treatment or service is not Medically Necessary or is Experimental/Investigational, benefits will be reduced or denied.
- You may be responsible for a penalty in connection with the following Covered Services, if indicated on your Schedule of Coverage:
 - Inpatient Hospital Admission
 - Inpatient treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Chemical Dependency

The penalty charge will be deducted from any benefit payment which may be due for Covered Services.

If an inpatient Hospital Admission, Extended Care Expense, Home Infusion Therapy, any treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Chemical Dependency or extension for any treatment or service described above is not Preauthorized and it is determined that the treatment, service, or extension was not Medically Necessary or Experimental/Investigational, benefits will be reduced or denied.

CLAIM FILING AND APPEALS PROCEDURES

CLAIM FILING PROCEDURES

Filing of Claims Required

Claim Forms

When the Claims Administrator receives notice of claim, it will furnish to you, or to your Employer for delivery to you, the Hospital, or your Physician or Professional Other Provider, the claim forms that are usually furnished by it for filing Proof of Loss.

The Claims Administrator for the Plan must receive claims prepared and submitted in the proper manner and form, in the time required, and with the information requested before it can consider any claim for payment of benefits.

Who Files Claims

Providers that contract with the Claims Administrator and some other health care Providers (such as *ParPlan* Providers) will submit your claims directly to the Claims Administrator for services provided to you or any of your covered Dependents. At the time services are provided, inquire if they will file claim forms for you. To assist Providers in filing your claims, you should carry your Identification Card with you.

Contracting Providers

When you receive treatment or care from a Provider or Covered Drugs dispensed from a Pharmacy that contracts with the Claims Administrator, you will generally not be required to file claim forms. The Provider will usually submit the claims directly to the Claims Administrator for you.

Non-Contracting Providers

When you receive treatment or care from a health care Provider or Covered Drugs dispensed from a Pharmacy that does not contract with the Claims Administrator, you may be required to file your own claim forms. Some Providers, however, will do this for you. If the Provider does not submit claims for you, refer to the subsection entitled *Participant-filed claims* below for instruction on how to file your own claim forms.

Mail-Order Program

When you receive Covered Drugs dispensed through the Mail-Order Program, you must complete and submit the mail service prescription drug claim form to the address on the claim form. Additional information may be obtained from your Employer, from the Claims Administrator, from the BCBSTX website, or by calling the Customer Service Helpline.

Participant-filed claims

- Medical Claims

If your Provider does not submit your claims, you will need to submit them to the Claims Administrator using a Subscriber-filed claim form provided by the Plan. Your Employer should have a supply of claim forms or you can obtain copies from the BCBSTX website. Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant's expenses separately because any Copayment Amounts, Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the health care Providers, labs, etc., printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

- Prescription Drug Claims

When you receive Covered Drugs dispensed from a non-Participating Pharmacy, a *Prescription Reimbursement Claim Form* must be submitted. This form can be obtained from the Claims Administrator or your Employer. This claim form, accompanied by an itemized bill obtained from the Pharmacy showing the prescription services you received, should be mailed to the address shown below or on the claim form.

Instructions for completing the claim form are provided on the back of the form. You may need to obtain additional information, which is not on the receipt from the pharmacist, to complete the claim form.

Bills for Covered Drugs should show the name, address and telephone number of the Pharmacy, a description and quantity of the drug, the prescription number, the date of purchase and most importantly, the name of the Participant using the drug.

VISIT THE BCBSTX WEBSITE FOR SUBSCRIBER CLAIM FORMS AND OTHER USEFUL INFORMATION
www.bcbstx.com

Where to Mail Completed Claim Forms

Medical Claims

Blue Cross and Blue Shield of Texas
Claims Division
P. O. Box 660044
Dallas, Texas 75266-0044

Prescription Drug Claims

Blue Cross and Blue Shield of Texas
c/o Prime Therapeutics LLC
P. O. Box 14624
Lexington, KY 40512-4624

Mail-Order Program Claims

Blue Cross and Blue Shield of Texas
c/o Prime Mail Pharmacy
P. O. Box 650041
Dallas, TX 75265-0041

Who Receives Payment

Benefit payments will be made directly to contracting Providers when they bill the Claims Administrator. Written agreements between the Claims Administrator and some Providers may require payment directly to them.

Any benefits payable to you, if unpaid at your death, will be paid to your surviving spouse, as beneficiary. If there is no surviving spouse, then the benefits will be paid to your estate.

Except as provided in the section **Assignment and Payment of Benefits**, rights and benefits under the Plan are not assignable, either before or after services and supplies are provided.

Benefit Payments to a Managing Conservator

Benefits for services provided to your minor Dependent child may be paid to a third party if:

- the third party is named in a court order as managing or possessory conservator of the child; and
- the Claims Administrator has not already paid any portion of the claim.

In order for benefits to be payable to a managing or possessory conservator of a child, the managing or possessory conservator must submit to the Claims Administrator, with the claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator.

The Claims Administrator for the Health Benefit Plan may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to you or your Provider, or deduction by the Plan from benefit payments of amounts owed to it, will be considered in satisfaction of its obligations to you under the Plan.

An *Explanation of Benefits* summary is sent to you so you will know what has been paid.

When to Submit Claims

All claims for benefits under the Health Benefit Plan must be properly submitted to the Claims Administrator within twelve (12) months of the date you receive the services or supplies. Claims submitted and received by the Claims Administrator after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by the Claims Administrator

A claim will be considered received by the Claims Administrator for processing upon actual delivery to the Administrative Office of the Claims Administrator in the proper manner and form and with all of the information required. If the claim is not complete, it may be denied or the Claims Administrator may contact either you or the Provider for the additional information.

After processing the claim, the Claims Administrator will notify the Participant by way of an *Explanation of Benefits* summary.

REVIEW OF CLAIM DETERMINATIONS

Claim Determinations

When the Claims Administrator receives a properly submitted claim, it has authority and discretion under the Plan to interpret and determine benefits in accordance with the Health Benefit Plan provisions. The Claims Administrator will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing between the Claims Administrator and the Plan Administrator. The Claims Administrator will render an initial decision to pay or deny a claim within 30 days of receipt of the claim. If the Claims Administrator requires further information in order to process the claim, the Claims Administrator will request it within that 30-day period.

You have the right to seek and obtain a full and fair review by the Claims Administrator of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by the Claims Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

If a Claim Is Denied or Not Paid in Full

On occasion, the Claims Administrator may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the *Explanation of Benefits* summary prepared by the Claims Administrator; then review this Benefit Booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to the Claims Administrator and request a review of the decision. Include your full name, group and subscriber numbers with the request.

If a claim for benefits is denied in whole or in part, you will receive a notice from the Claims Administrator within the following time limits:

- The reason for denial;
- A reference to the Health Benefit Plan provisions on which the denial is based;
- A description of additional information which may be necessary to complete the claim and an explanation of why such information is necessary; and
- An explanation of how you may have the claim reviewed by the Claims Administrator if you do not agree with the denial.

Right to Review Claim Determinations

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by the Claim Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

If you believe the Claims Administrator incorrectly denied all or part of your benefits, you may have your claim reviewed. The Claims Administrator will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of a denial or partial denial, write to the Claim Administrator's Administrative Office. The Claims Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

Claim Review Section
Blue Cross and Blue Shield of Texas
P.O. Box 660044
Dallas, TX 75266-0044

- You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.
- The Claims Administrator will honor telephone requests for information. However, such inquiries will not constitute a request for review.
- You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. The Claim Administrator will give you a written decision within 60 days after it receives your request for review.
- If you have any questions about the claims procedures or the review procedure, write to the Claims Administrator's Administrative Office or call the toll-free Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.

Preauthorization Appeal Procedures

If you or your Physician disagree with the determination of the Preauthorization prior to or while receiving services, you may appeal that decision by contacting the Claims Administrator's Administrative Office.

In some instances, the resolution of the appeal process will not be completed until your inpatient admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter from the Claims Administrator, you may request a review of that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Claim Review Section
Blue Cross and Blue Shield of Texas
P.O. Box 660044
Dallas, TX 75266-0044

Once you have requested this review, you may submit additional information and comments on your Preauthorization decision to the Claims Administrator as long as you do so within 30 days of the date you ask for a review. Also, during this 30-day period, you may review any documents relevant to your Preauthorization decision held by the Claims Administrator.

Within 30 days of receiving your request to review, the Claims Administrator will send you its decision on the claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30-day period.

Interpretation of Employer's Plan Provisions

The Plan Administrator has given the Claims Administrator the initial authority to establish or construe the terms and conditions of the Health Benefit Plan and the discretion to interpret and determine benefits in accordance with the Health Benefit Plan's provisions.

The Plan Administrator has all powers and authority necessary or appropriate to control and manage the operation and administration of the Health Benefit Plan.

All powers to be exercised by the Claims Administrator or the Plan Administrator shall be exercised in a non-discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

Claim Dispute Resolution

You must exhaust all administrative remedies as described in the **Review of Claims Determinations** section prior to taking further action under your Health Benefit Plan.

After exhaustion of all remedies offered by the Claims Administrator, you may exercise your right to appeal all adverse determinations with the Plan Administrator of your Health Benefit Plan. The Plan Administrator is the final interpreter of the Health Benefit Plan and may correct any defect, supply any omission, or reconcile any inconsistency or ambiguity in such manner as it deems advisable. All final determinations and actions concerning the Health Benefit Plan administration and interpretation of benefits shall be made by the Plan Administrator. The Claims Administrator will cooperate in providing the Plan Administrator documents relevant to the claim or Preauthorization decision upon receipt of a valid written authorization from you or your representative to release the relevant information.

If you have a claim for benefits which is denied or ignored, in whole or in part, and your Health Benefit Plan is governed by the Employee Retirement Income Security Act (ERISA), you may file suit under 502(a) of ERISA.

ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Eligible Expenses

The Plan provides coverage for the following categories of Eligible Expenses:

- Inpatient Hospital Expenses,
- Medical–Surgical Expenses,
- Extended Care Expenses, and
- Special Provisions Expenses

Wherever Schedule of Coverage is mentioned, please refer to your Schedule(s) in this Benefit Booklet. Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

Copayment Amounts

Some of the care and treatment you receive under the Plan will require that a Copayment Amount be paid at the time you receive the services. Refer to your Schedule of Coverage under “Copayment Amounts Required” for your specific Plan information.

A Copayment Amount will be required for most Physician office visits, including lab and x-ray. If the services provided by your Physician require a return office visit (lab services for instance) on a different day, a new Copayment Amount will be required. A Copayment Amount will be required for the initial office visit for Maternity Care, but will not be required for subsequent visits.

The following services are not payable under this Copayment Amount provision but instead are considered Medical–Surgical Expense and may be subject to any Deductible shown on your Schedule of Coverage:

- surgery performed in the Physician’s office;
- physical therapy billed separately from an office visit;
- occupational modalities in conjunction with physical therapy;
- allergy injections billed separately from an office visit;
- therapeutic injections;
- any services requiring Preauthorization;
- Certain Diagnostic Procedures;
- services provided by an Independent Lab, Imaging Center, radiologist, pathologist, and anesthesiologist;
- outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.

Deductibles

The benefits of the Plan will be available after satisfaction of the applicable Deductibles as shown on your Schedule of Coverage. The Deductibles are explained as follows:

Per-admission Deductible: The per-admission Deductible shown under “Deductibles” on your Schedule of Coverage will apply to **each** inpatient Hospital Admission of a Participant.

Calendar Year Deductible: The individual Deductible amount shown under “Deductibles” on your Schedule of Coverage must be satisfied by each Participant under your coverage each Calendar Year. This Deductible will be applied to all Medical–Surgical Expenses, Extended Care Expenses, and Special Provisions Expenses (unless otherwise indicated) before benefits are available under the Plan.

The following are exceptions to the Deductibles described above:

Your Schedule of Coverage indicates “Three–Month Deductible carryover applies.” This means that any Eligible Expenses incurred during the last three months of a Calendar Year and applied toward satisfaction of the “Calendar Year Deductible” for that Calendar Year may be applied toward satisfaction of the Deductible for the following Calendar Year.

If you have several covered Dependents, all charges used to apply toward a “per individual” Deductible amount will be applied toward the “per family” Deductible amount shown on your Schedule of Coverage. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Calendar Year. No Participant will contribute more than the individual Deductible amount to the “per family” Deductible amount.

Eligible Expenses applied toward satisfying the “per individual” and “per family” Out-of-Network Deductible will apply toward both the Out-of-Network and the In-Network Deductible. However, Eligible Expenses applied toward satisfying the “per individual” and “per family” In-Network Deductible will not apply toward satisfying the Out-of-Network Deductible.

Co-Share Stop-Loss Amount

Most of your Eligible Expense payment obligations, including Copayment Amounts, are considered Co-Share Amounts and are applied to the Co-Share Stop-Loss Amount maximum.

Your Co-Share Stop-Loss Amount will **not** include:

- Services, supplies, or charges limited or excluded by the Plan;
- Expenses not covered because a benefit maximum has been reached;
- Any Eligible Expenses paid by the Primary Plan when the Plan is the Secondary Plan for purposes of coordination of benefits;
- Deductibles;
- Penalties applied for failure to Preauthorize;
- Any Copayment Amounts paid under your Pharmacy Benefits;
- Any remaining unpaid Medical-Surgical Expense in excess of the benefits provided for Covered Drugs.

Individual Co-Share Stop-Loss Amount

When the Co-Share Amount for the In-Network or Out-of-Network Benefits level for a Participant in a Calendar Year equals the “per individual” “Co-Share Stop-Loss Amount” shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant for the remainder of that Calendar Year for that level.

Family Co-Share Stop-Loss Amount

When the Co-Share Amount for the In-Network or Out-of-Network Benefits level for all Participants under your coverage in a Calendar Year equals the “per family” “Co-Share Stop-Loss Amount” shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by all family Participants for the remainder of that Calendar Year for that level. No Participant will be required to contribute more than the individual Co-Share Stop-Loss Amount to the family “Co-Share Stop-Loss Amount.”

The following are exceptions to the Co-Share Stop-Loss Amounts described above:

There are separate Co-Share Stop-Loss Amounts for In-Network Benefits and Out-of-Network Benefits.

Eligible Expenses applied toward satisfying the “per individual” and “per family” Out-of-Network Co-Share Stop-Loss Amount maximum will apply toward both the In-Network and Out-of-Network Co-Share Stop-Loss Amount. However, Eligible Expenses applied toward satisfying the “per individual” and “per family” In-Network Co-Share Stop-Loss Amount maximum will not apply toward satisfying the Out-of-Network Co-Share Stop-Loss Maximum amount.

Copayment Amounts for In-Network Benefits and Out-of-Network Benefits will continue to be required after the benefit percentages become 100%.

Changes In Benefits

Changes to covered benefits will apply to all services provided to each Participant under the Plan. Benefits for Eligible Expenses incurred during an admission in a Hospital or Facility Other Provider that begins before the change will be those benefits in effect on the day of admission.

COVERED MEDICAL SERVICES

Inpatient Hospital Expenses

The Plan provides coverage for Inpatient Hospital Expenses for you and your eligible Dependents. Each inpatient Hospital Admission requires Preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for additional information.

The benefit percentage of your total eligible Inpatient Hospital Expense, in excess of any Deductible, shown under “Inpatient Hospital Expenses” on your Schedule of Coverage is the Plan’s obligation. The remaining unpaid Inpatient Hospital Expense, in excess of any Deductible, is your obligation to pay. This excess amount will be applied to the Co-Share Amounts.

Services and supplies provided by an Out-of-Network Provider will receive In-Network Benefits when those services and supplies are not available from a Network Provider provided the Claims Administrator acknowledges your visit to an Out-of-Network Provider **prior** to the visit. Otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate.

Refer to your Schedule of Coverage for information regarding Deductibles, Co-Share percentages, and penalties for failure to Preauthorize that may apply to your coverage.

Medical-Surgical Expenses

The Plan provides coverage for Medical-Surgical Expense for you and your covered Dependents. Some services require Preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

Copayment Amounts must be paid to your Network Physician or other Network Providers at the time you receive services.

The benefit percentages of your total eligible Medical-Surgical Expense shown under “Medical-Surgical Expenses” on your Schedule of Coverage in excess of your Copayment Amounts, Co-Share Amounts, and any applicable Deductibles shown are the Plan’s obligation. The remaining unpaid Medical-Surgical Expense in excess of the Copayment Amounts, Co-Share Amounts, and any Deductibles is your obligation to pay.

Medical-Surgical Expense shall include:

1. Services of Physicians and Professional Other Providers. If services are received from a Licensed Professional Counselor, a professional recommendation should be obtained from the Physician.
2. Consultation services of a Physician and Professional Other Provider.
3. Services of a certified registered nurse-anesthetist (CRNA).
4. Diagnostic x-ray and laboratory procedures.
5. Radiation therapy.
6. Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by the Plan. The term “durable medical equipment (DME)” shall not include:
 - a. Equipment primarily designed for alleviation of pain or provision of patient comfort; or
 - b. Home air fluidized bed therapy.

Examples of non-covered equipment include, but are not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment.

7. Professional local ambulance service to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition.
8. Anesthetics and its administration, when performed by someone other than the operating Physician or Professional Other Provider.
9. Oxygen and its administration provided the oxygen is actually used.
10. Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Participant.
11. Prosthetic Appliances, including replacements necessitated by growth to maturity of the Participant.
12. Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces, casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.
13. Home Infusion Therapy.
14. Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or a Chemical Dependency Treatment Center, or scheduled services in the outpatient treatment room of a Hospital.
15. Certain Diagnostic Procedures.
16. Outpatient Contraceptive Services and prescription contraceptive devices. NOTE: Prescription oral contraceptive medications are covered under the **PHARMACY BENEFITS** portion of your Plan.
17. Telehealth Services and Telemedicine Medical Services.
18. Foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes.
19. Drugs that have not been approved by the FDA for self-administration when injected, ingested, or applied in a Physician's or Professional Other Provider's office.
20. Elective Abortions.
21. Elective Sterilizations.

Extended Care Expenses

The Plan also provides benefits for Extended Care Expenses for you and your covered Dependents. All Extended Care Expenses require Preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

The Plan's benefit obligation as shown on your Schedule of Coverage will be:

1. At the benefit percentage under "Extended Care Expenses," and
2. Up to the number of days or visits shown for each category of Extended Care Expenses.

All payments made by the Plan, whether under the In-Network or Out-of-Network Benefit level, will apply toward the combined benefit maximums.

If shown on your Schedule of Coverage, the Calendar Year Deductible will apply. Any unpaid Extended Care Expenses in excess of the benefit maximums shown on your Schedule of Coverage will not be applied to any Co-Share Stop-Loss Amount.

Any charges incurred as Home Health Care or home Hospice Care for drugs (including antibiotic therapy) and laboratory services will not be Extended Care Expenses but will be considered Medical-Surgical Expenses.

Services and supplies for Extended Care Expenses:

1. For Skilled Nursing Facility:

- a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
- b. Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;
- c. Physical, occupational, speech, and respiratory therapy services by licensed therapists.

2. For Home Health Care:

- a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
- b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
- c. Physical, occupational, speech, and respiratory therapy services by licensed therapists;
- d. Supplies and equipment routinely provided by the Home Health Agency.

Benefits will **not** be provided for Home Health Care for the following:

- Food or home delivered meals;
- Social case work or homemaker services;
- Services provided primarily for Custodial Care;
- Transportation services;
- Home Infusion Therapy;
- Durable medical equipment.

3. For Hospice Care:

Home Hospice Care:

- a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
- b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
- c. Physical, speech, and respiratory therapy services by licensed therapists;
- d. Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.

Facility Hospice Care:

- a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
- b. Room and board and all routine services, supplies, and equipment provided by the Hospice facility;
- c. Physical, speech, and respiratory therapy services by licensed therapists.

Special Provisions Expenses

The benefits available under this **Special Provisions Expenses** subsection are generally determined on the same basis as other Inpatient Hospital Expenses, Medical-Surgical Expenses, and Extended Care Expenses, except to the extent described in each item. Benefits for Medically Necessary expenses will be determined as indicated on your Schedule(s) of Coverage. Remember that certain services require Preauthorization and that any Copayment Amounts, Co-Share Amounts, and Deductibles shown on your Schedule(s) of Coverage will also apply. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

Benefits for Treatment of Complications of Pregnancy

Benefits for Eligible Expenses incurred for treatment of Complications of Pregnancy will be determined on the same basis as treatment for any other sickness. Dependent children will be eligible for treatment of Complications of Pregnancy.

Benefits for Maternity Care

Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other treatment of sickness. A Copayment Amount will be required for the initial office visit for Maternity Care, but will not be required for subsequent visits. Dependent children will be eligible for Maternity Care benefits.

Services and supplies incurred by a Participant for delivery of a child shall be considered Maternity Care and are subject to all provisions of the Plan.

The Plan provides coverage for inpatient care for the mother and newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery; and
- 96 hours following an uncomplicated delivery by caesarean section.

Charges for well-baby nursery care, including the initial examination, of a newborn child during the mother's Hospital Admission for the delivery will be considered Inpatient Hospital Expense of the child and will be subject to the benefit provisions as described under **Inpatient Hospital Expenses**. Benefits will also be subject to any Deductible amounts shown on your Schedule of Coverage.

Benefits for Mental Health Care, Serious Mental Illness, and Treatment of Chemical Dependency

Benefits for Eligible Expenses incurred for Mental Health Care, treatment of Serious Mental Illness and treatment of Chemical Dependency will be the same as for treatment of any other sickness. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection to determine what services require Preauthorization.

Any Eligible Expenses incurred for the services of a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents for Medically Necessary Mental Health Care or treatment of Serious Mental Illness in lieu of inpatient hospital services will, for the purpose of this benefit, be considered **Inpatient Hospital Expenses**.

Inpatient treatment of Chemical Dependency must be provided in a Chemical Dependency Treatment Center. However, treatment in a Hospital for the medical management of acute life-threatening intoxication (toxicity) will be an exception to this provision.

Benefits for Emergency Care and Treatment of Accidental Injury

The Plan provides coverage for medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

If reasonably possible, contact your Network Physician or Behavioral Health Practitioner before going to the Hospital emergency room/treatment room. He can help you determine if you need Emergency Care or treatment of an Accidental Injury and recommend that care. If not reasonably possible, go to the nearest emergency facility, whether or not the facility is in the Network.

Whether you require hospitalization or not, you should notify your Network Physician or Behavioral Health Practitioner within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so he can recommend the continuation of any necessary medical services.

Benefits for Eligible Expenses for Accidental Injury or Emergency Care, including Accidental Injury or Emergency Care for Behavioral Health Services, will be determined as shown on your Schedule of Coverage. If admitted for the emergency condition immediately following the visit, Preauthorization of the inpatient Hospital Admission will be required.

All treatment received following the onset of an accidental injury or emergency care will be eligible for In-Network Benefits. For a non-emergency, In-Network Benefits will be available only if you use Network Providers. For a non-emergency, if you can safely be transferred to the care of a Network Provider but are treated by an Out-of-Network Provider, only Out-of-Network Benefits will be available

Benefits for Preventive Care

Benefits for Medical–Surgical Expenses are available for the following preventive care services as indicated on your Schedule of Coverage:

- well–baby care (after the newborn’s initial examination and discharge from the Hospital);
- routine annual physical examination, including routine lab and x–ray;
- annual vision examination;
- annual hearing examinations, except for benefits as provided under ***Benefits for Screening Tests for Hearing Impairment***;
- immunizations for Participants age six and over.

Benefits for childhood immunizations will be provided as described in Benefits for Childhood Immunizations for children under the age of six. Benefits are not available for Inpatient Hospital Expenses or Medical–Surgical Expenses for routine physical examinations performed on an inpatient basis, except for the initial examination of a newborn child.

Injections for allergies are not considered immunizations under this benefit provision.

Benefits for Mammography Screening

Benefits are available for a screening by low–dose mammography for the presence of occult breast cancer for a Participant on the same basis as any other preventive care service shown on your Schedule of Coverage, except that benefits will not be available for more than one routine mammography screening each Calendar Year.

Benefits for Detection and Prevention of Osteoporosis

If a Participant is a *Qualified Individual*, benefits are available for medically accepted bone mass measurement for the detection of low bone mass and to determine a Participant’s risk of osteoporosis and fractures associated with osteoporosis, on the same basis as any other preventive care service shown on your Schedule of Coverage.

Qualified Individual means:

- a. A postmenopausal woman not receiving estrogen replacement therapy;
- b. An individual with:
 - vertebral abnormalities,
 - primary hyperparathyroidism, or
 - a history of bone fractures; or
- c. An individual who is:
 - receiving long–term glucocorticoid therapy, or
 - being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Benefits for Tests for Detection of Colorectal Cancer

Benefits are available for a diagnostic, medically recognized screening examination for the detection of colorectal cancer, for Participants who are 50 years of age or older and who are at normal risk for developing colon cancer, include:

- A fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years; or
- A colonoscopy performed every ten years.

Benefits will be provided for Physician services and facility expenses on the same basis as any other preventive care service shown on your Schedule of Coverage.

Benefits for Certain Tests for Detection of Human Papillomavirus and Cervical Cancer

Benefits are available for certain tests for detection of Human Papillomavirus and Cervical Cancer for each woman enrolled in the Plan who is 18 years of age or older, for an annual medically recognized diagnostic examination for the early detection of cervical cancer, on the same basis as any other preventive care service shown on your Schedule of Coverage. Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the United States Food and Drug Administration (FDA) alone or in combination with a test approved by the FDA for the detection of the human papillomavirus.

Benefits for Certain Tests for Detection of Prostate Cancer

Benefits are available on the same basis as any other preventive care service shown on your Schedule of Coverage for an annual medically recognized diagnostic physical examination for the detection of prostate cancer and a prostate-specific antigen test used for the detection of prostate cancer for each male under the Plan who is at least:

- 50 years of age and asymptomatic; or
- 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Benefits for Childhood Immunizations

Benefits for Medical-Surgical Expenses incurred by a Dependent child for childhood immunizations will be determined at 100% of the Allowable Amount. Deductibles, Copayment Amounts, and Co-Share Amounts will not be applicable.

Benefits are available for:

- Diphtheria,
- Hemophilus influenza type b,
- Hepatitis B,
- Measles,
- Mumps,
- Pertussis,
- Polio,
- Rubella,
- Tetanus,
- Varicella, and
- Any other immunization that is required by law for the child.

Injections for allergies are not considered immunizations under this benefit provision.

Benefits for Speech and Hearing Services

Benefits as shown on your Schedule of Coverage are available for the services of a Physician or Professional Other Provider to restore loss of or correct an impaired speech or hearing function.

Any benefit payments made by the Claims Administrator for hearing aids, whether under the In-Network or Out-of-Network Benefits level, will apply toward the benefit maximum indicated on your Schedule of Coverage.

Benefits for Certain Therapies for Children with Developmental Delays

Medical-Surgical Expense benefits are available to a covered Dependent child for the necessary rehabilitative and habilitative therapies in accordance with an Individualized Family Service Plan.

Such therapies include:

- occupational therapy evaluations and services;
- physical therapy evaluations and services;
- speech therapy evaluations and services; and
- dietary or nutritional evaluations

The *Individualized Family Service Plan* must be submitted to the Claims Administrator prior to the commencement of services and when the Individualized Family Service Plan is altered.

Once the child reaches the age of three, when services under the *Individualized Family Service Plan* are completed, Eligible Expenses, as otherwise covered under this Plan, will be available. All contractual provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.

Developmental Delay means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:

- Cognitive development;
- Physical development;
- Communication development;
- Social or emotional development; or
- Adaptive development.

Individualized Family Service Plan means an initial and ongoing treatment plan.

Benefits for Screening Tests for Hearing Impairment

Benefits are available for Eligible Expenses incurred by a covered Dependent child:

- For a screening test for hearing loss from birth through the date the child is 30 days old; and
- Necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months.

Deductibles indicated on your Schedule of Coverage will not apply to this provision.

Benefits for Cosmetic, Reconstructive, or Plastic Surgery

The following Eligible Expenses described below for Cosmetic, Reconstructive, or Plastic Surgery will be the same as for treatment of any other sickness as shown on your Schedule of Coverage:

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant; or
- Treatment provided for reconstructive surgery following cancer surgery; or
- Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
- Surgery performed on a covered Dependent child (other than a newborn child) under the age of 19 for the treatment or correction of a congenital defect other than conditions of the breast; or
- Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy; or
- Reconstructive surgery performed on a covered Dependent child under the age of 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Benefits for Dental Services

Benefits for Eligible Expenses incurred by a Participant will be provided on the same basis as for treatment of any other sickness as shown on your Schedule of Coverage only for the following:

- Covered Oral Surgery;
- Services provided to a newborn child which are necessary for treatment or correction of a congenital defect; or
- The correction of damage caused solely by external, violent Accidental Injury to healthy, un-restored natural teeth and supporting tissues and limited to treatment provided within 24 months of the initial treatment. An injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.

Any other dental services, except as excluded in the **MEDICAL LIMITATIONS AND EXCLUSIONS** section of this Benefit Booklet, for which a Participant incurs Inpatient Hospital Expenses for a Medically Necessary inpatient Hospital Admission, will be determined as described in **Benefits for Inpatient Hospital Expenses**.

Benefits for Organ and Tissue Transplants

- a. Subject to the conditions described below, benefits for covered services and supplies provided to a Participant by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:

- (1) The transplant procedure is not Experimental/Investigational in nature; and
- (2) Donated human organs or tissue or an FDA-approved artificial device are used; and
- (3) The recipient is a Participant under the Plan; and
- (4) The transplant procedure is Preauthorized as required under the Plan; and
- (5) The Participant meets all of the criteria established by the Claims Administrator in pertinent written medical policies; and
- (6) The Participant meets all of the protocols established by the Hospital in which the transplant is performed.

Covered services and supplies “related to” an organ or tissue transplant include, but are not limited to, x-rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

- b. Benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is considered Medically Necessary and meets all of the conditions cited above.

Benefits will be available for:

- (1) A recipient who is covered under this Plan; and
- (2) A donor who is a Participant under this Plan.

- c. Covered services and supplies include services and supplies provided for the:

- (1) Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and
- (2) Removal of organs or tissues from living or deceased donors; and
- (3) Transportation and short-term storage of donated organs or tissues.

- d. No benefits are available for a Participant for the following services or supplies:

- (1) Donor search and acceptability testing of potential live donors;
- (2) Living and/or travel expenses of the recipient or a live donor;
- (3) Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
- (4) Purchase of the organ or tissue; or
- (5) Organs or tissue (xenograft) obtained from another species.

- e. Preauthorization is required for any organ or tissue transplant. Review the **PREAUTHORIZATION REQUIREMENTS** subsection in this Benefit Booklet for more specific information about Preauthorization.

- (1) Such specific Preauthorization is required even if the patient is already a patient in a Hospital under another Preauthorization authorization.
- (2) At the time of Preauthorization, the Claims Administrator will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if the Claims Administrator determines that an extension is Medically Necessary.

- f. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which the Claims Administrator considers to be Experimental/Investigational.

Benefits for Treatment of Acquired Brain Injury

Benefits for Eligible Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Eligible Expenses include the following *services* as a result of and related to an Acquired Brain Injury:

- Cognitive communication therapy – *Services* designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information;
- Cognitive rehabilitation therapy – *Services* designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits;
- Community reintegration services – *Services* that facilitate the continuum of care as an affected individual transitions into the community;
- Neurobehavioral testing – An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others;
- Neurobehavioral treatment – Interventions that focus on behavior and the variables that control behavior;
- Neurocognitive rehabilitation – *Services* designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques;
- Neurocognitive therapy – *Services* designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities;
- Neurofeedback therapy – *Services* that utilizes operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood;
- Neurophysiological testing – An evaluation of the functions of the nervous system;
- Neurophysiological treatment – Interventions that focus on the functions of the nervous system;
- Neuropsychological testing – The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning;
- Neuropsychological treatment – Interventions designed to improve or minimize deficits in behavioral and cognitive processes;
- Post-acute transition services – *Services* that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration;
- Psychophysiological testing – An evaluation of the interrelationships between the nervous system and other bodily organs and behavior;
- Psychophysiological treatment – Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors;
- Remediation – The process(es) of restoring or improving a specific function.

Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.

Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.

Benefits for Treatment of Diabetes

Benefits are available and will be determined on the same basis as any other sickness for those Medically Necessary items for *Diabetes Equipment* and *Diabetes Supplies* (for which a Physician or Professional Other Provider has written an order) and *Diabetic Management Services/Diabetes Self-Management Training*. Such items, when obtained for a *Qualified Participant*, shall include but not be limited to the following:

a. *Diabetes Equipment*

- (1) Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind);
- (2) Insulin pumps (both external and implantable) and associated appurtenances, which include:
 - Insulin infusion devices,
 - Batteries,
 - Skin preparation items,
 - Adhesive supplies,
 - Infusion sets,
 - Insulin cartridges,
 - Durable and disposable devices to assist in the injection of insulin, and
 - Other required disposable supplies; and
- (3) Podiatric appliances, including up to two pairs of therapeutic footwear per Calendar Year, for the prevention of complications associated with diabetes.

b. *Diabetes Supplies*

- (1) Test strips specified for use with a corresponding blood glucose monitor,
- (2) Visual reading and urine test strips and tablets for glucose, ketones, and protein,
- (3) Lancets and lancet devices,
- (4) Insulin and insulin analog preparations,
- (5) Injection aids, including devices used to assist with insulin injection and needleless systems,
- (6) Biohazard disposable containers,
- (7) Insulin syringes,
- (8) Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
- (9) Glucagon emergency kits.

NOTE: *All Diabetes Supplies listed in item b above will be covered under the Pharmacy Benefits portion of your plan.*

- c. Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.
- d. As new or improved treatment and monitoring equipment or supplies become available and are approved by the FDA, such equipment or supplies may be covered if determined to be Medically Necessary and appropriate by the treating Physician or Professional Other Provider who issues the written order for the supplies or equipment.
- e. Medical-Surgical Expense provided for the nutritional, educational, and psychosocial treatment of the *Qualified Participant*. Such *Diabetic Management Services/Diabetes Self-Management Training* for which a Physician or Professional Other Provider has written an order to the Participant or caretaker of the Participant is limited to the following when rendered by or under the direction of a Physician.

Initial and follow-up instruction concerning:

- (1) The physical cause and process of diabetes;
- (2) Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;
- (3) Prevention and treatment of special health problems for the diabetic patient;
- (4) Adjustment to lifestyle modifications; and
- (5) Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

Diabetes Self-Management Training for the *Qualified Participant* will include the development of an individualized management plan that is created for and in collaboration with the *Qualified Participant* (and/or his or her family) to understand the care and management of diabetes, including nutritional counseling and proper use of *Diabetes Equipment* and *Diabetes Supplies*.

A *Qualified Participant* means an individual eligible for coverage under this Plan who has been diagnosed with (a) insulin dependent or non-insulin dependent diabetes, (b) elevated blood glucose levels induced by pregnancy, or (c) another medical condition associated with elevated blood glucose levels.

Benefits for Physical Medicine Services

Benefits for Medical-Surgical Expenses incurred for Physical Medicine Services are available and will be determined on the same basis as treatment for any other sickness shown on your Schedule of Coverage.

Benefits for Chiropractic Services

Benefits for Medical-Surgical Expenses incurred for Chiropractic Services are available as shown on your Schedule of Coverage.

However, Chiropractic Services benefits for all visits during which physical treatment is rendered, whether under the In-Network or Out-of-Network Benefits level, will not be provided for more than the maximum number of visits (outpatient facility and office combined) shown on your Schedule of Coverage. Any visits during which no physical treatment is rendered will not count toward the visit maximum.

Benefits for Vision Care

Benefits for Eligible Expenses incurred for Vision Care are available and will be determined up to the combined maximum benefit amount shown on your Schedule of Coverage.

Benefits are available for the following covered items:

- Conventional lenses, including single vision, bifocal vision, trifocal, and lenticular. You may choose progressive lenses (no-line bifocals), polycarbonate lenses, scratch resistant coating, ultra-violet coating, solid tint, gradient tint, photochromic, and anti-reflective coating.
- Contact lenses, for Aphakic conditions (cannot correct to 20/40) or for conditions other than Aphakic (can correct to 20/40)

All benefit payments made by the Claims Administrator for Vision Care, whether under the In-Network or Out-of-Network Benefits level, will apply toward the combined benefit maximum.

MEDICAL LIMITATIONS AND EXCLUSIONS

The benefits as described in this Benefit Booklet are not available for:

1. Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.
2. Any Experimental/Investigational services and supplies.
3. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by the Claims Administrator.
4. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
5. Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
6. Any services or supplies for which a Participant is not required to make payment or for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage, except services or supplies for treatment of mental illness or mental retardation provided by a tax supported institution of the State of Texas.
7. Any services or supplies provided by a person who is related to the Participant by blood or marriage.
8. Any services or supplies provided for injuries sustained:
 - As a result of war, declared or undeclared, or any act of war; or
 - While on active or reserve duty in the armed forces of any country or international authority.
9. Any charges:
 - Resulting from the failure to keep a scheduled visit with a Physician or Professional Other Provider; or
 - For completion of any insurance forms; or
 - For acquisition of medical records.
10. Room and board charges incurred during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Participant's physical condition or the quality of medical care provided.
11. Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage.
12. Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Plan for:
 - an inpatient nutritional assessment program provided in and by a Hospital and approved by the Claims Administrator; or
 - ***Benefits for Treatment of Diabetes*** as described in **Special Provisions Expenses**; or
 - ***Benefits for Certain Therapies for Children with Developmental Delays*** as described in **Special Provisions Expenses**.

13. Any services or supplies provided for Custodial Care.
14. Any non-surgical (dental restorations, orthodontics, or physical therapy) or non-diagnostic services or supplies (oral appliances, oral splints, oral orthotics, devices, or prosthetics) provided for the treatment of the temporomandibular joint (including the jaw and craniomandibular joint) and all adjacent or related muscles.
15. Any items of Medical-Surgical Expenses incurred for dental care and treatments, dental surgery, or dental appliances, except as provided for in the ***Benefits for Dental Services*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
16. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as provided for in the ***Benefits for Cosmetic, Reconstructive, or Plastic Surgery*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
17. Any services or supplies provided for:
 - Treatment of myopia and other errors of refraction, including refractive surgery; or
 - Orthoptics or visual training; or
 - Eyeglasses or contact lenses, provided that intraocular lenses shall be specific exceptions to this exclusion, except as may be provided under the ***Benefits for Vision Care*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet; or
 - Examinations for the prescription or fitting of eyeglasses or contact lenses; or
 - Restoration of loss or correction to an impaired speech or hearing function, except as may be provided under the ***Benefits for Speech and Hearing Services*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
18. Except as specifically included as an Eligible Expense, any Medical Social Services, any outpatient family counseling and/or therapy, bereavement counseling, vocational counseling, or Marriage and Family Therapy and/or counseling.
19. Any services or supplies provided for treatment of adolescent behavior disorders, including conduct disorders and opposition disorders.
20. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function, except as may be provided under the ***Benefits for Physical Medicine Services*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
21. Travel or ambulance services because it is more convenient for the patient than other modes of transportation whether or not recommended by a Physician or Professional Other Provider.
22. Any services or supplies provided primarily for:
 - Environmental Sensitivity;
 - Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
 - Inpatient allergy testing or treatment.
23. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
24. Any services or supplies provided for, in preparation for, or in conjunction with:
 - Sterilization reversal (male or female);
 - Transsexual surgery;
 - Sexual dysfunctions;
 - In vitro fertilization; and
 - Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.

25. Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of severe systemic disease.
26. Any services or supplies in connection with foot care for flat feet, fallen arches, and chronic foot strain.
27. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
28. Supplies for smoking cessation programs and the treatment of nicotine addiction.
29. Any services or supplies provided for the following treatment modalities:
 - acupuncture;
 - intersegmental traction;
 - surface EMGs;
 - spinal manipulation under anesthesia; and
 - muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
30. Any services or supplies furnished by a Contracting Facility for which such facility has not been specifically approved to furnish under a written contract or agreement with the Claims Administrator will be paid at the Out-of-Network benefit level.
31. Any items that include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a Physician in a non-hospital setting or purchased “over the counter” for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts.

NOTE: This exclusion does not apply to podiatric appliances when provided as Diabetic Equipment.
32. Any benefits in excess of any specified dollar, day/visit, or Calendar Year maximums.
33. Any services and supplies provided to a Participant incurred outside the United States if the Participant traveled to the location for the purposes of receiving medical services, supplies, or drugs.
34. Donor expenses for a Participant in connection with an organ and tissue transplant if the recipient is not covered under this Plan.
35. Replacement Prosthetic Appliances except those necessitated by growth due to maturity of the Participant.
36. Private duty nursing services, except for covered Extended Care Expenses.
37. Any Covered Drugs for which benefits are available under the Pharmacy Benefits portion of the Plan.
38. Any services or supplies provided for reduction mammoplasty.
39. Any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight.
40. Biofeedback, except for an Acquired Brain Injury diagnosis, or other behavior modification services.
41. Any related services to a non-covered service. Related services are:
 - Services in preparation for the non-covered service;
 - Services in connection with providing the non-covered service;
 - Hospitalization required to perform the non-covered service; or
 - Services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.
42. Any services or supplies not specifically defined as Eligible Expenses in this Plan.

DEFINITIONS

The definitions used in this Benefit Booklet apply to all coverage unless otherwise indicated.

Accidental Injury means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a Physician or Professional Other Provider.

Acquired Brain Injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Allowable Amount means the maximum amount determined by the Claims Administrator (BCBSTX) to be eligible for consideration of payment for a particular service, supply, or procedure.

- ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers contracting with the Claims Administrator in Texas or any other Blue Cross and Blue Shield Plan*** – The Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.
- ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers not contracting with the Claims Administrator in Texas*** – The Allowable Amount will be the lesser of: (i) the Provider's billed charges, or; (ii) the BCBSTX non-contracting Allowable Amount. Except as otherwise provided in this section, the non-contracting Allowable Amount is developed from base Medicare Participating reimbursements adjusted by a predetermined factor established by the Claims Administrator. Such factor shall be not less than 75% and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

Notwithstanding the preceding sentence, the non-contracting Allowable Amount for Home Health Care is developed from base Medicare national per visit amounts for low utilization payment adjustment, or LUPA, episodes by Home Health discipline type adjusted for duration and adjusted by a predetermined factor established by the Claims Administrator. Such factor shall be not less than 75% and shall be updated on a periodic basis.

When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on the claim, the Allowable Amount for non-contracting Providers will represent an average contract rate in aggregate for Network Providers adjusted by a predetermined factor established by the Claims Administrator. Such factor shall be not less than 75% and shall be updated not less than every two years.

The Claims Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by non-contracted Providers which may also alter the Allowable Amount for a particular service. In the event the Claims Administrator does not have any claim edits or rules, the Claims Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Amount will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claims Administrator within ninety (90) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

The non-contracting Allowable Amount does not equate to the Provider's billed charges and Participants receiving services from a non-contracted Provider will be responsible for the difference between the non-contracting Allowable Amount and the non-contracted Provider's billed charge, and this difference may be considerable. To find out the BCBSTX non-contracting Allowable Amount for a particular service, Participants may call customer service at the number on the back of your BCBSTX Identification Card.

- ***For multiple surgeries*** – The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus a determined percentage of the Allowable Amount for each of the other covered procedures performed.
- ***For procedures, services, or supplies provided to Medicare recipients*** – The Allowable Amount will not exceed Medicare's limiting charge.

- **For Covered Drugs as applied to Participating and non-Participating Pharmacies** - The Allowable Amount for Participating Pharmacies and the Mail-Order Program will be based on the provisions of the contract between the Claims Administrator and the Participating Pharmacy or Pharmacy for the Mail-Order Program in effect on the date of service. The Allowable Amount for non-Participating Pharmacies will be based on the Participating Pharmacy contract rate.

Behavioral Health Practitioner means a Physician or Professional Other Provider who renders services for Mental Health Care, Serious Mental Illness or Chemical Dependency, only as listed in this Benefit Booklet.

Calendar Year means the period commencing on January 1 and ending on the next succeeding December 31, inclusive.

Certain Diagnostic Procedures means:

- Bone Scan
- Cardiac Stress Test
- CT Scan (with or without contrast)
- MRI (Magnetic Resonance Imaging)
- Myelogram
- PET Scan (Positron Emission Tomography)

Chemical Dependency means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

Chemical Dependency Treatment Center means a facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Behavioral Health Practitioner and which facility is also:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
2. Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
3. Licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
4. Licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

Chiropractic Services means any services or supplies provided by or under the direction of a Doctor of Chiropractic.

Claims Administrator means Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX, as part of its duties as Claims Administrator, may subcontract portions of its responsibilities.

Clinical Ecology means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:

1. Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);
2. Urine auto injection (injecting one's own urine into the tissue of the body);
3. Skin irritation by Rinkel method;
4. Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or
5. Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

Complications of Pregnancy means:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but *shall not include* false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy, and
2. Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution with which the Claims Administrator has executed a written contract for the provision of care, services, or supplies furnished within the scope of its license for benefits available under the Plan. A Contracting Facility shall also include a Hospital or Facility Other Provider located outside the State of Texas, and with which any other Blue Cross Plan has executed such a written contract; provided, however, any such facility that fails to satisfy each and every requirement contained in the definition of such institution or facility as provided in the Plan shall be deemed a Non-Contracting Facility regardless of the existence of a written contract with another Blue Cross Plan.

Copayment Amount means the payment, as expressed in dollars, that must be made by or on behalf of a Participant for certain services at the time they are provided.

Co-Share Amount means the dollar amount of Eligible Expenses including Copayment Amounts incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan. Refer to **Co-Share Stop-Loss Amount** in **ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS** of the Benefit Booklet for additional information.

Cosmetic, Reconstructive, or Plastic Surgery means surgery that:

1. Can be expected or is intended to improve the physical appearance of a Participant; or
2. Is performed for psychological purposes; or
3. Restores form but does not correct or materially restore a bodily function.

Covered Oral Surgery means maxillofacial surgical procedures limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
2. Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology;
3. Incision and drainage of facial abscess; and
4. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses.

Creditable Coverage means coverage provided under:

1. A group health plan that is a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974;
2. Health insurance coverage consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital, or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes:
 - a. group health insurance coverage;
 - b. individual health insurance coverage; and
 - c. short-term, limited-duration insurance;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid) other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines);
5. Title 10 Chapter 55, *United States Code* (medical and dental care for members and certain former members of the uniformed services and for their dependents);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A State health benefits risk pool;
8. A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program);
9. A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;
10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504 (e)); or
11. Title XXI of the Social Security Act (State Children's Health Insurance Program).

Creditable Coverage does not include:

1. Coverage only for accident (including accidental death and dismemberment);
2. Disability income coverage;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Coverage issued as a supplement to liability insurance;
5. Workers' compensation or similar coverage;
6. Automobile medical payment insurance;
7. Credit-only insurance (for example, mortgage insurance);
8. Coverage for onsite medical clinics;
9. Limited scope dental benefits, vision benefits, or long-term care benefits if they are provided under a separate policy, certificate, or contract of insurance.
10. Flexible spending accounts (FSAs) if they meet the definition of a health FSA in IRC Sec. 106(c)(2) and (a) the maximum benefit payable for the employee under the FSA for the year does not exceed two times the employee's salary reduction election under the FSA for the year; and (b) the employee has other coverage available under a group health plan of the employer for the year; and (c) the other coverage is not limited to benefits that are excepted benefits;
11. Coverage for only a specified disease or illness or Hospital indemnity or other fixed indemnity insurance;
12. Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), also known as Medigap or MedSupp insurance);
13. Coverage supplemental to the coverage provided under Chapter 55, Title 10, *United States Code* (also known as TRICARE supplemental programs); and
14. Similar supplemental coverage provided to coverage under a group health plan.

Crisis Stabilization Unit or Facility means an institution which is appropriately licensed and accredited as a Crisis Stabilization Unit or Facility for the provision of Mental Health Care and Serious Mental Illness services to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

Custodial Care means care comprised of services and supplies, including room and board and other institutional services, provided to a Participant primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or injury. *Custodial Care* is care which is not a necessary part of medical treatment for recovery, and shall include, but not be limited to, helping a Participant walk, bathe, dress, eat, prepare special diets, and take medication.

Deductible means the dollar amount of Eligible Expenses that must be incurred by a Participant before benefits under the Plan will be available.

Dependent means:

1. Your legal spouse (spouses who are eligible for medical coverage through his/her employer are not eligible for medical coverage under this Plan);
2. A *child* up to age 26; and
3. An unmarried *child* of any age who is medically certified as disabled.

A *Child* may be:

- a. Your son or daughter; or
- b. Your stepson or stepdaughter; or
- c. A child of your child who is your dependent for federal income tax purposes at the time application of coverage of the child of your child is made; or
- d. A legally adopted individual; or
- e. An individual who is lawfully placed with the Employee for legal adoption; or
- f. An eligible foster child; or
- g. A child for whom a Participant has received a court order requiring the Participant to take financial responsibility for providing health insurance.

For purposes of this Plan, the term *Dependent* will also include those individuals who no longer meet the definition of a Dependent, but are beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Dietary and Nutritional Services means the education, counseling, or training of a Participant (including printed material) regarding:

1. Diet;
2. Regulation or management of diet; or
3. The assessment or management of nutrition.

Durable Medical Equipment Provider means a Provider that provides therapeutic supplies and rehabilitative equipment and is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Effective Date means the date the coverage for a Participant actually begins. It may be different from the Eligibility Date.

Eligibility Date means the date the Participant satisfies the definition of either “Employee” or “Dependent” and is in a class eligible for coverage under the Plan as described in the **WHO GETS BENEFITS** section of this Benefit Booklet.

Eligible Expenses mean either, Inpatient Hospital Expenses, Medical–Surgical Expenses, Extended Care Expenses, or Special Provisions Expenses, as described in this Benefit Booklet.

Emergency Care means health care services provided in a Hospital emergency facility (emergency room) or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that the person’s condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

1. placing the patient’s health in serious jeopardy;
2. serious impairment of bodily functions;
3. serious dysfunction of any bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Employee means a person who:

1. Regularly provides personal services at the Employee’s usual and customary place of employment with the Employer; and
2. Works, full time, 30 or more hours per week as required by the Employer; and
3. Is recorded as an Employee on the payroll records of the Employer; and
4. Is compensated for services by salary or wages. If applicable to this group, proprietors, partners, corporate officers and directors need not be compensated for services by salary or wages.

For purposes of this plan, the term *Employee* will also include those individuals who are no longer an Employee of the Employer, but who are participants covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Employer means the person, firm, or institution named on this Benefit Booklet.

Environmental Sensitivity means the inpatient or outpatient treatment of allergic symptoms by:

1. Controlled environment; or
2. Sanitizing the surroundings, removal of toxic materials; or
3. Use of special non–organic, non–repetitive diet techniques.

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, *medical treatment* includes medical, surgical, or dental treatment.

Standard medical treatment means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the Hospital or Facility Other Provider in which they were performed; and
- the Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The Claims Administrator for the Plan shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination.

Although a Physician or Professional Other Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, the Claims Administrator still may determine such services or supplies to be Experimental/Investigational within this definition. Treatment provided as part of a clinical trial or a research study is Experimental/Investigational.

Extended Care Expenses means the Allowable Amount of charges incurred for those Medically Necessary services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice as described in the **Extended Care Expenses** portion of this Benefit Booklet.

Group Health Plan (GHP) as applied to this Benefit Booklet means a self-funded employee welfare benefit plan as defined in subsection 160.103 of HIPAA. For additional information, refer to the definition of Plan Administrator.

Health Benefit Plan means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a Health Maintenance Organization that provides benefits for health care services. The term does not include:

1. Accident only or disability income insurance, or a combination of accident-only and disability income insurance;
2. Credit-only insurance;
3. Disability insurance coverage;
4. Coverage for a specified disease or illness;
5. Medicare services under a federal contract;
6. Medicare supplement and Medicare Select policies regulated in accordance with federal law;
7. Long-term care coverage or benefits, home health care coverage or benefits, nursing home care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;
8. Coverage that provides limited-scope dental or vision benefits;
9. Coverage provided by a single service health maintenance organization;
10. Coverage issued as a supplement to liability insurance;
11. Workers' compensation or similar insurance;
12. Automobile medical payment insurance coverage;
13. Jointly managed trusts authorized under 29 U.S.C. Section 141, et seq., that;
 - contain a plan of benefits for employees
 - is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees, and
 - is authorized under 29 U.S.C. Section 157;
14. Hospital indemnity or other fixed indemnity insurance;
15. Reinsurance contracts issued on a stop-loss, quota-share, or similar basis;
16. Short-term major medical contracts;
17. Liability insurance, including general liability insurance and automobile liability insurance;
18. Other coverage that is:
 - similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other insurance benefits; and
 - specified in federal regulations;
19. Coverage for onsite medical clinics; or
20. Coverage that provides other limited benefits specified by federal regulations.

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Home Health Agency means a business that provides Home Health Care and is licensed, approved, or certified by the appropriate agency of the state in which it is located or be certified by Medicare as a supplier of Home Health Care.

Home Health Care means the health care services for which benefits are provided under the Plan when such services are provided during a visit by a Home Health Agency to patients confined at home due to a sickness or injury requiring skilled health services on an intermittent, part-time basis.

Home Infusion Therapy means the administration of fluids, nutrition, or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:

1. Drugs and IV solutions;
2. Pharmacy compounding and dispensing services;
3. All equipment and ancillary supplies necessitated by the defined therapy;
4. Delivery services;
5. Patient and family education; and
6. Nursing services.

Over-the-counter products which do not require a Physician's or Professional Other Provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Home Infusion Therapy Provider means an entity that is duly licensed by the appropriate state agency to provide Home Infusion Therapy.

Hospice means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which is:

1. Licensed in accordance with state law (where the state law provides for such licensing); or
2. Certified by Medicare as a supplier of Hospice Care.

Hospice Care means services for which benefits are provided under the Plan when provided by a Hospice to patients confined at home or in a Hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

Hospital means a short-term acute care facility which:

1. Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital provider under Medicare;
2. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians or Behavioral Health Practitioners for compensation from its patients;
3. Has organized departments of medicine and major surgery, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, and maintains clinical records on all patients;
4. Provides 24-hour nursing services by or under the supervision of a Registered Nurse;
5. Has in effect a Hospital Utilization Review Plan; and
6. Is not, other than incidentally, a Skilled Nursing Facility, nursing home, Custodial Care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the treatment of Chemical Dependency, Hospice, or place for the provision of rehabilitative care.

Hospital Admission means the period between the time of a Participant's entry into a Hospital or a Chemical Dependency Treatment Center as a *Bed patient* and the time of discontinuance of bed-patient care or discharge by the admitting Physician, Behavioral Health Practitioner or Professional Other Provider, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a Hospital Admission. If a Participant is admitted to and discharged from a Hospital within a 24-hour period but is confined as a *Bed patient* in a bed accommodation during the period of time he is confined in the Hospital, the admission shall be considered a Hospital Admission by the Claims Administrator.

Bed patient means confinement in a bed accommodation of a Chemical Dependency Treatment Center on a 24-hour basis or in a bed accommodation located in a portion of a Hospital which is designed, staffed, and operated to provide acute, short-term Hospital care on a 24-hour basis; the term does not include confinement in a portion of the Hospital (other than a Chemical Dependency Treatment Center) designed, staffed, and operated to provide long-term institutional care on a residential basis.

Identification Card means the card issued to the Employee by the Claims Administrator of the Plan indicating pertinent information applicable to his coverage.

Imaging Center means a Provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the Department of State Health Services Certificate of Equipment Registration and/or Department of State Health Services Radioactive Materials License.

Independent Laboratory means a Medicare certified laboratory that provides technical and professional anatomical and/or clinical laboratory services.

In-Network Benefits means the benefits available under the Plan for services and supplies that are provided by a Network Provider or an Out-of-Network Provider when acknowledged by the Claims Administrator.

Inpatient Hospital Expense means the Allowable Amount incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided that such items are:

1. Furnished at the direction or prescription of a Physician, Behavioral Health Practitioner or Professional Other Provider; and
2. Provided by a Hospital or a Chemical Dependency Treatment Center; and
3. Furnished to and used by the Participant during an inpatient Hospital Admission.

An expense shall be deemed to have been incurred on the date of provision of the service for which the charge is made.

Inpatient Hospital Expense shall include:

1. Room accommodation charges. If the Participant is in a private room, the amount of the room charge in excess of the Hospital's average semiprivate room charge *is not* an Eligible Expense.
2. All other usual Hospital services, including drugs and medications, which are Medically Necessary and consistent with the condition of the Participant. Personal items *are not* an Eligible Expense.

Medically Necessary Mental Health Care or treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents, in lieu of hospitalization, shall be Inpatient Hospital Expense.

Late Enrollee means any Employee or Dependent eligible for enrollment who requests enrollment in an Employer's Health Benefit Plan (1) after the expiration of the initial enrollment period established under the terms of the first plan for which that Participant was eligible through the Employer, (2) after the expiration of an Open Enrollment Period, or (3) after the expiration of a special enrollment period.

An Employee or a Dependent is *not* a Late Enrollee if:

1. The individual:
 - a. Was covered under another Health Benefit Plan or self-funded Health Benefit Plan at the time the individual was eligible to enroll; and
 - b. Declines in writing, at the time of initial eligibility, stating that coverage under another Health Benefit Plan or self-funded Health Benefit Plan was the reason for declining enrollment; and
 - c. Has lost coverage under another Health Benefit Plan or self-funded Health Benefit Plan as a result of:
 - (1) termination of employment;
 - (2) reduction in the number of hours of employment;
 - (3) termination of the other plan's coverage;
 - (4) termination of contributions toward the premium made by the Employer;
 - (5) COBRA coverage has been exhausted;
 - (6) cessation of Dependent status;
 - (7) the Plan no longer offers any benefits to the class of similarly situated individuals that include the individual; or
 - (8) in the case of coverage offered through an HMO, the individual no longer resides, lives, or works in the service area of the HMO and no other benefit option is available; and
 - d. Requests enrollment not later than the 31st day after the date on which coverage under the other Health Benefit Plan or self-funded Health Benefit Plan terminates or in the event of the attainment of a lifetime limit on all benefits, the individual must request to enroll not later than 31 days after a claim is denied due to the attainment of a lifetime limit on all benefits.
2. The request for enrollment is made by the individual within the 60th day after the date on which coverage under Medicaid or CHIP terminates.
3. The individual is employed by an Employer who offers multiple Health Benefit Plans and the individual elects a different Health Benefit Plan during an Open Enrollment Period.
4. A court has ordered coverage to be provided for a spouse under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the court order is issued.
5. A court has ordered coverage to be provided for a child under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the Employer receives notice of the court order.
6. A Dependent child is not a Late Enrollee if the child:
 - a. Was covered under Medicaid or the Children's Health Insurance Program (CHIP) at the time the child was eligible to enroll;
 - b. The employee declined coverage for the child in writing, stating that coverage under Medicaid or CHIP was the reason for declining coverage;
 - c. The child has lost coverage under Medicaid or CHIP; and
 - d. The request for enrollment is made within the 60th day after the date on which coverage under Medicaid or CHIP terminates.

Marriage and Family Therapy means the provision of professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.

Maternity Care means care and services provided for treatment of the condition of pregnancy, other than Complications of Pregnancy.

Medical Social Services means those social services relating to the treatment of a Participant's medical condition. Such services include, but are not limited to assessment of the:

1. Social and emotional factors related to the Participant's sickness, need for care, response to treatment, and adjustment to care; and
2. Relationship of the Participant's medical and nursing requirements to the home situation, financial resources, and available community resources.

Medical-Surgical Expenses means the Allowable Amount for those charges incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided such items are:

1. Furnished by or at the direction or prescription of a Physician, Behavioral Health Practitioner or Professional Other Provider; and
2. Not included as an item of Inpatient Hospital Expense or Extended Care Expense in the Plan.

A service or supply is furnished at the direction of a Physician, Behavioral Health Practitioner or Professional Other Provider if the listed service or supply is:

1. Provided by a person employed by the directing Physician, Behavioral Health Practitioner or Professional Other Provider; and
2. Provided at the usual place of business of the directing Physician, Behavioral Health Practitioner or Professional Other Provider; and
3. Billed to the patient by the directing Physician, Behavioral Health Practitioner or Professional Other Provider.

An expense shall have been incurred on the date of provision of the service for which the charge is made.

Medically Necessary or **Medical Necessity** means those services or supplies covered under the Plan which are:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and
2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
3. Not primarily for the convenience of the Participant, his Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider; and
4. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.

The medical staff of the Claims Administrator shall determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Physician, Behavioral Health Practitioner or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

Mental Health Care means any one or more of the following:

1. The diagnosis or treatment of a mental disease, disorder, or condition listed in the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*, as revised, or any other diagnostic coding system as used by the Claims Administrator, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin;
2. The diagnosis or treatment of any symptom, condition, disease, or disorder by a Physician, Behavioral Health Practitioner or Professional Other Provider (or by any person working under the direction or supervision of a Physician, Behavioral Health Practitioner or Professional Other Provider) when the Eligible Expense is:
 - a. Individual, group, family, or conjoint psychotherapy,
 - b. Counseling,
 - c. Psychoanalysis,
 - d. Psychological testing and assessment,
 - e. The administration or monitoring of psychotropic drugs, or
 - f. Hospital visits or consultations in a facility listed in subsection 5, below;
3. Electroconvulsive treatment;
4. Psychotropic drugs;
5. Any of the services listed in subsections 1 through 4, above, performed in or by a Hospital, Facility Other Provider, or other licensed facility or unit providing such care.

Non-Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution which has not executed a written contract with BCBSTX for the provision of care, services, or supplies for which benefits are provided by the Plan. Any Hospital, Facility Other Provider, facility, or institution with a written contract with BCBSTX which has expired or has been canceled is a Non-Contracting Facility.

Open Enrollment Period means the period preceding the next Plan Anniversary Date during which Employees and Dependents may enroll for coverage, typically November of each Plan year.

Other Provider means a person or entity, other than a Hospital or Physician, that is licensed where required to furnish to a Participant an item of service or supply described herein as Eligible Expenses. Other Provider shall include:

1. **Facility Other Provider** – an institution or entity, only as listed:
 - a. Chemical Dependency Treatment Center
 - b. Crisis Stabilization Unit or Facility
 - c. Durable Medical Equipment Provider
 - d. Home Health Agency
 - e. Home Infusion Therapy Provider
 - f. Hospice
 - g. Imaging Center
 - h. Independent Laboratory
 - i. Prosthetics/Orthotics Provider
 - j. Psychiatric Day Treatment Facility
 - k. Renal Dialysis Center
 - l. Residential Treatment Center for Children and Adolescents
 - m. Skilled Nursing Facility
 - n. Therapeutic Center
2. **Professional Other Provider** – a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:
 - a. Advanced Practice Nurse
 - b. Doctor in Psychology
 - c. Doctor of Chiropractic
 - d. Doctor of Dentistry
 - e. Doctor of Optometry
 - f. Doctor of Osteopathy
 - g. Doctor of Podiatry
 - h. Licensed Audiologist
 - i. Licensed Chemical Dependency Counselor
 - j. Licensed Clinical Social Worker
 - k. Licensed Dietitian
 - l. Licensed Hearing Instrument Fitter and Dispenser
 - m. Licensed Marriage and Family Therapist
 - n. Licensed Occupational Therapist
 - o. Licensed Physical Therapist
 - p. Licensed Professional Counselor
 - q. Licensed Speech-Language Pathologist
 - r. Licensed Surgical Assistant
 - s. Nurse First Assistant
 - t. Physician Assistant
 - u. Psychological Associates who work under the supervision of a Doctor in Psychology

In states where there is a licensure requirement, other Providers must be licensed by the appropriate state administrative agency.

Out-of-Network Benefits means the benefits available under the Plan for services and supplies that are provided by an Out-of-Network Provider.

Out-of-Network Provider means a Hospital, Physician, Behavioral Health Practitioner, or Other Provider who has not entered into an agreement with BCBSTX (or other participating Blue Cross and/or Blue Shield Plan) as a managed care Provider.

Outpatient Contraceptive Services means a consultation, examination, procedure, or medical service that is provided on an outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy.

Participant means an Employee or Dependent whose coverage has become effective under this Plan.

Physical Medicine Services means those modalities, procedures, tests, and measurements listed in the *Physicians' Current Procedural Terminology Manual* (Procedure Codes 97010-97799), whether the service or supply is provided by a Physician or Professional Other Provider, and includes, but is not limited to, physical therapy, occupational therapy, hot or cold packs, whirlpool, diathermy, electrical stimulation, massage, ultrasound, manipulation, muscle or strength testing, and orthotics or prosthetic training.

Physician means a person, when acting within the scope of his license, who is a Doctor of Medicine or Doctor of Osteopathy.

Plan means a program of health and welfare benefits established for the benefit of its Participants whether the plan is subject to the rules and regulations of the Employee's Retirement and Income Security Act (ERISA) or, for government and/or church plans, where compliance is voluntary.

Plan Administrator means the Group Health Plan (GHP) or a named administrator of the Plan having fiduciary responsibility for its operation. BCBSTX is not the Plan Administrator.

Plan Anniversary Date means the day, month, and year of the 12-month period following the Plan Effective Date and corresponding date in each year thereafter for as long as this Benefit Booklet is in force.

Plan Effective Date means the date on which coverage for the Employer's Plan begins with the Claims Administrator.

Plan Month means each succeeding calendar month period, beginning on the Plan Effective Date.

Plan Service Area means the geographical area(s) or areas in which a Network of Providers is offered and available and is used to determine eligibility for **Managed Health Care Plan** benefits.

Preauthorization means the process that determines in advance the Medical Necessity or Experimental/Investigational nature of certain care and services under this Plan.

Proof of Loss means written evidence of a claim including:

1. The form on which the claim is made;
2. Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim, and
3. Correct diagnosis code(s) and procedure code(s) for the services and items.

Prosthetic Appliances means artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). For purposes of this definition, a wig or hairpiece is not considered a Prosthetic Appliance.

Prosthetics/Orthotics Provider means a certified prosthetist that supplies both standard and customized prostheses and orthotic supplies.

Provider means a Hospital, Physician, Behavioral Health Practitioner, Other Provider, or any other person, company, or institution furnishing to a Participant an item of service or supply listed as Eligible Expenses.

Psychiatric Day Treatment Facility means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a Psychiatric Day Treatment Facility for the provision of Mental Health Care and Serious Mental Illness services to Participants for periods of time not to exceed eight hours in any 24-hour period. Any treatment in a Psychiatric Day Treatment Facility must be certified in writing by the attending Physician or Behavioral Health Practitioner to be in lieu of hospitalization.

Renal Dialysis Center means a facility which is Medicare certified as an end-stage renal disease facility providing staff assisted dialysis and training for home and self-dialysis.

Residential Treatment Center for Children and Adolescents means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provisions of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

Serious Mental Illness means the following psychiatric illnesses defined by the *American Psychiatric Association in the Diagnostic and Statistical Manual (DSM)*:

1. Bipolar disorders (hypomanic, manic, depressive, and mixed);
2. Depression in childhood and adolescence;
3. Major depressive disorders (single episode or recurrent);
4. Obsessive-compulsive disorders;
5. Paranoid and other psychotic disorders;
6. Schizo-affective disorders (bipolar or depressive); and
7. Schizophrenia.

Skilled Nursing Facility means a facility primarily engaged in providing skilled nursing services and other therapeutic services and which is:

1. Licensed in accordance with state law (where the state law provides for licensing of such facility); or
2. Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care.

Specialty Care Provider means a Physician or Professional Other Provider who has entered into an agreement with Claims Administrator (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider of specialty services with the exception of a family practitioner, obstetrician/gynecologist, pediatrician, Behavioral Health Practitioner, an internist or a Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these.

Telehealth Service means a health service, other than a Telemedicine Medical Service, delivered by a licensed or certified health professional Provider acting within the scope of the health care professional Provider's license or certification who does not perform a Telemedicine Medical Service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

1. Compressed digital interactive video, audio, or data transmission;
2. Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
3. Other technology that facilitates access to health care services or medical specialty expertise.

Telemedicine Medical Service means a health care service initiated by a Physician or provided by a health professional Provider acting under Physician delegation and supervision for purposes of patient assessment by a health professional, diagnosis, or consultation by a Physician, treatment or the transfer of medical data that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

1. Compressed digital interactive video, audio or data transmission;
2. Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
3. Other technology that facilitates access to health care services or medical specialty expertise.

Therapeutic Center means an institution which is appropriately licensed, certified, or approved by the state in which it is located and which is:

1. An ambulatory (day) surgery facility;
2. A freestanding radiation therapy center; or
3. A freestanding birthing center.

Waiting Period means a period of time that must pass before an individual who is a potential enrollee in a Health Benefit Plan is eligible to be covered for benefits. Benefits are effective on the first day of the pay period following 75 days of employment.

PHARMACY BENEFITS

Covered Drugs

Benefits are available for Medically Necessary Covered Drugs prescribed to treat a Participant for a condition, sickness, disease, injury, or bodily malfunction covered under the Plan if the drug:

1. Has been approved by the United States Food and Drug Administration (FDA) for at least one indication; and
2. Is recognized by the following for treatment of the indication for which the drug is prescribed
 - a. a prescription drug reference compendium, approved by the appropriate state agency, or
 - b. substantially accepted peer-reviewed medical literature.

As new drugs are approved by the FDA, such drugs, unless the intended use is specifically excluded under the Plan, are eligible for benefits. Some equivalent drugs are manufactured under multiple brand names. In such cases, BCBSTX may limit benefits to only one of the brand equivalents available. Benefits are available for Covered Drugs as indicated on your Schedule of Coverage.

Injectable Drugs

Injectable drugs approved by the FDA for self-administration are covered under the Plan. Injectable drugs include, but are not limited to, insulin and Imitrex.

The day supply of disposable syringes and needles you will need for self-administered injections will be limited on each occasion dispensed to amounts appropriate to the dosage amounts of covered injectable drugs actually prescribed and dispensed, but cannot exceed 100 syringes and needles per Prescription Order in a 30-day period.

Diabetes Supplies for Treatment of Diabetes

Benefits are available for Medically Necessary items of Diabetes Supplies for which a Physician or authorized Health Care Practitioner has written a Prescription Order. Such Diabetes Supplies, when obtained for a Qualified Participant (for more information regarding Qualified Participant, refer to the ***Benefits for Treatment of Diabetes*** section of the medical portion of this Benefit Booklet), shall include but not be limited to the following:

- Test strips specified for use with a corresponding blood glucose monitor
- Lancets and lancet devices
- Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein
- Insulin and insulin analog preparations
- Injection aids, including devices used to assist with insulin injection and needleless systems
- Insulin syringes
- Biohazard disposable containers
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
- Glucagon emergency kits

Specialty Drugs

Benefits are available for Specialty Drugs obtained from a retail Pharmacy or through the Specialty Pharmacy Program. Specialty Drugs are generally prescribed to treat a chronic, complex medical condition. They often require careful adherence to treatment plans, have special handling and storage requirements, and may not be stocked by all retail Pharmacies.

A list identifying these Specialty Drugs is available by accessing the website at www.bcbstx.com and following the link to the specialty prescription drugs preferred list. You may also contact Customer Service at the toll-free number shown in this Benefit Booklet or on your Identification Card for information pertaining to the specialty prescription drugs preferred list.

Selecting a Pharmacy

Participating Pharmacy

If a Prescription Order is filled or refilled at, or if you receive a covered vaccination from, a Participating Pharmacy:

- present your Identification Card to the pharmacist along with your Prescription Order,
- provide the pharmacist with the birth date and relationship of the patient,
- sign the insurance claim log,
- pay your portion of the cost as described in **Your Cost**, if any, for each Prescription Order filled or refilled or for each covered vaccination received.

Participating Pharmacies have agreed to accept as payment in full the least of:

- the billed charges, or
- the Allowable Amount as determined by the Claims Administrator, or
- other contractually determined payment amounts.

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may access our website at www.bcbstx.com or contact Customer Service at the toll-free number shown in this Benefit Booklet or on your Identification Card.

Non-Participating Pharmacy

If a Prescription Order is filled or refilled at, or a covered vaccination is received from, a non-Participating Pharmacy, you must pay the Pharmacy the full amount of its bill and submit a claim form to the Claims Administrator with itemized receipts verifying that the Prescription Order was filled or refilled, or a covered vaccination was administered. The Plan will reimburse you up to the Allowable Amount of the Covered Drugs dispensed, or covered vaccination administered, less your portion of the cost as described in **Your Cost**. Any amount of the billed charge in excess of the Allowable Amount is your responsibility to pay and is in addition to all other costs that you may be required to pay.

Mail-Order Program

The Mail-Order Program provides delivery of Covered Drugs directly to the Participant's residence. If you or a covered Dependent elects to use the Mail-Order Program, you must mail a completed mail-order prescription form along with the Prescription Order and your portion of the cost as described in **Your Cost** to the address indicated on the mail-order prescription form.

Some drugs may not be available through the Mail-Order Program. If you have any questions about this Mail-Order Program, need assistance in determining the amount of your payment, or need to obtain the mail-order prescription form, you may access the website at www.bcbstx.com or contact Customer Service at the toll-free number shown in this Benefit Booklet or on your Identification Card.

If you send an incorrect payment amount for the Covered Drug dispensed, you will either receive a credit if the payment is too much or be billed for the appropriate amount if it is not enough.

Specialty Pharmacy Program

The Specialty Pharmacy Program offers a Specialty Drug delivery service and integrates benefits for Specialty Drugs with your overall medical and prescription drug benefits. This program provides the option of having Specialty Drugs delivered directly to your Health Care Practitioner, the location where the drug will be administered, or to your residence.

Some of the benefits of using the Specialty Pharmacy Program include:

- Coordination of coverage among you, your Health Care Practitioner, and BCBSTX;
- Educational materials about the patient's particular condition and information about managing potential medication side effects;
- Syringes, sharps containers, alcohol swabs, and other supplies with every shipment of FDA-approved self-injectable medications; and
- Access to a pharmacist for urgent medication issues 24 hours a day, 7 days a week, 365 days each year.

In addition, the Specialty Pharmacy Program may often offer the most cost effective approach to obtaining your Specialty Drugs. To being using the Specialty Pharmacy Program for a new Prescription Order, to transfer your existing Prescription Order, or for more information about the Specialty Pharmacy Program, you or your Physician may contact Customer Service at the toll-free number shown in this Benefit Booklet or on your Identification Card. You will be responsible for the Specialty Drug Copayment Amount as described in **Your Cost**.

Your Cost

Copayment Amounts

Your cost for each Prescription Order filled or refilled includes a Copayment Amount. The amount you pay depends on the Covered Drug dispensed. If the Covered Drug dispensed is a:

1. Generic Drug – You pay the Generic Drug Copayment Amount
2. Preferred Brand Name Drug – You pay the Preferred Brand Name Drug Copayment Amount
3. Non-Preferred Brand Name Drug – You pay the Non-Preferred Brand Name Drug Copayment Amount
4. Specialty Drug – You pay the Specialty Drug Copayment Amount

Copayment Amounts are shown on your Schedule of Coverage. If the Allowable Amount of the Covered Drug is less than the Copayment Amount, you will pay the lower cost.

Additional Costs

If there is no generic equivalent for a Prescription Order specifying a Brand Name Drug, you will pay no more than the appropriate Copayment Amount for the Brand Name Drug dispensed.

However, if a Brand Name Drug is dispensed when a generic equivalent is available, you will pay an additional amount over and above the Copayment Amount. The additional amount will be equal to the difference between the Allowable Amount of the generic equivalent and the Allowable Amount of the Brand Name Drug dispensed.

Drug Coupons, Rebates, or Other Drug Discounts

Drug manufacturers may offer coupons, rebates, or other drug discounts to Participants that may impact the benefits provided under this Plan. The total benefits payable will not exceed the balance of the Allowable Amount remaining after all drug coupons, rebates, or other drug discounts have been applies. The Participant shall be responsible for reimbursing BCBSTX any excess amounts of benefits paid in the event drug coupons, rebates, or other drug discounts are applied to a Prescription Order.

About Your Benefits

Preferred Drug List 1

A Preferred Brand Name Drug is subject to the Preferred Brand Name Drug Copayment Amount plus any additional costs that may apply to the Covered Drug you receive. These drugs are identified on the *Preferred Drug List 1* that is maintained by BCBSTX. This list is developed using monographs written by the American Medical Association, Academy of Managed Care Pharmacies, and other Pharmacy and medical related organizations, describing clinical outcomes, drug efficacy, and side effect profiles.

BCBSTX will routinely review the *Preferred Drug List 1* and periodically adjust it to modify the Preferred or Non-Preferred Brand Name Drug status of existing or new drugs. Changes to this list will be implemented on the Employer's Plan Anniversary Date. The *Preferred Drug List 1* and any modifications will be made available to Participants. Participants may access our website at www.bcbstx.com or contact Customer Service at the toll-free number shown in this Benefit Booklet or on your Identification Card to determine if a particular drug is on the *Preferred Drug List 1*. Drugs that do not appear on the *Preferred Drug List 1* may be subject to the Non-Preferred Brand Name Drug Copayment Amount plus any additional costs that may apply to the Covered Drug received.

Day Supply

Benefits for Covered Drugs are provided up to the maximum day supply limit as indicated on your Schedule of Coverage. The Copayment Amounts applicable for the designated day supply of dispensed drugs are also indicated on your Schedule of Coverage. BCBSTX has the right to determine the day supply. Payment for benefits covered under this Plan may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation.

Benefits will be provided for prescription drugs dispensed in the following quantities:

- Retail Pharmacies and Specialty Drug Pharmacies – during each one-month period, up to a 30-day supply or 120 units (e.g. pills), whichever is less. If more than 120 units are needed to reach a 30 day supply, another Copayment Amount will apply to each additional 120 units (or portion thereof) purchased. In addition, for Prescription Orders filled or re-filled at a retail Pharmacy, you may choose to receive up to a 90-day supply or 360 units (e.g. pills), whichever is less, provided that you pay the appropriate Copayment Amount for each 30-day supply received.
- Mail-Order Program – during each three-month period, up to a 90-day supply or 360 units (e.g. pills), whichever is less. If less than a 90-day supply is ordered, the Mail-Order Program Copayment Amount will apply to each additional 360 units (or portion thereof) purchased.

For commercially packaged items (such as an inhaler, a tube of ointment, or a blister pack of tablets or capsules), you will pay the applicable Copayment Amount for each package, regardless of the days' supply the package represents. For example, if two inhalers are purchased under the retail Pharmacy, two Copayment Amounts will apply. Under the Mail-Order Program, you can receive up to three times the number of packages obtainable from a retail Pharmacy for the applicable Mail-Order Program Copayment Amount.

Benefits are not provided under this Plan for charges for prescription drugs dispensed in excess of the amounts stated above.

If you are leaving the country, or need an extended supply of medication, contact Customer Service at the toll-free number shown in this Benefit Booklet or on your Identification Card at least two weeks before you intend to leave. Extended supplies or vacation overrides are not available through the Mail-Order Program, but may be approved through the retail Pharmacy only. In some cases, you may be asked to provide proof of continued enrollment eligibility under the Plan.

Dispensing Quantity Versus Time Limits

The maximum quantity of a given prescription drug indicates the number of units to be dispensed and is determined based on pertinent medical information and clinical efficacy and safety. Quantities of some drugs are restricted regardless of the quantity ordered by the Health Care Practitioner. To determine if a specific drug is subject to this limitation, you may access the website at www.bcbstx.com or contact Customer Service at the toll-free number shown in this Benefit Booklet or on your Identification Card.

If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by a Health Care Practitioner, the Prescription Order will only be covered for a clinically appropriate pre-determined quantity of medication for the specified amount of time. Dispensing limits are based upon FDA dosing recommendations and nationally recognized clinical guidelines.

If you require a Prescription Order in excess of the dispensing limit established by BCBSTX, ask your Health Care Practitioner to submit a request for clinical review on your behalf. The Health Care Practitioner can obtain an override request form by accessing our website at www.bcbstx.com. Any pertinent medical information along with the completed form should be faxed to Clinical Pharmacy Programs at the fax number indicated on the form. The request will be approved or denied after evaluation of the submitted clinical information. BCBSTX has the right to determine dispensing limits at its sole discretion. Payment for benefits covered by under this Plan may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum quantity limitation.

Right of Appeal

In the event that a requested Prescription Order is still denied on the basis of quantity versus time dispensing limits with or without your authorized Health Care Practitioner having submitted clinical documentation, you have the right to appeal as indicated under the **Review of Claim Determinations** section of this Benefit Booklet.

Limitations and Exclusions

Benefits are not available for:

1. Drugs which do not by law require a Prescription Order from a Provider (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels); and Legend Drugs or covered devices for which no valid Prescription Order is obtained.
2. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order,) such as, but not limited to, contraceptive devices, therapeutic devices (including support garments and other non-medicinal substances), artificial appliances, or similar devices (provided that disposable hypodermic needles and syringes for self-administered injections and those devices listed as Diabetes Supplies shall be specific exceptions to this exclusion). NOTE: Coverage for contraceptive devices is provided under the medical portion of this Plan.
3. Administration or injection of any drugs.
4. Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is **no** non-prescription alternative).
5. Drugs injected, ingested, or applied in a Physician's or authorized Health Care Practitioner's office or during confinement while a patient is in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
6. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
7. Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this section shall not be applicable to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
8. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery.
9. Covered Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Participant's cost share determined under this Plan.
10. Contraceptive devices and non-prescription contraceptive materials (**except** prescription contraceptive drugs which are Legend Drugs.) NOTE: Coverage for contraceptive devices is provided under the medical portion of this Plan.
11. Oral and injectable infertility and fertility medications.
12. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
13. Drugs required by law to be labeled: "Caution - Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs.
14. Drugs dispensed in quantities in excess of the day supply amounts stipulated in your Schedule of Coverage and as described under the **Day Supply** subsection of this Benefit Booklet, certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or authorized Health Care Practitioner or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.

15. Legend Drugs which are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.
16. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) administered or intended to be administered in the home setting by:
 - intravenous or gastrointestinal (enteral) infusion;
 - intravenous injection;
 - intramuscular (in the muscle) injection;
 - intrathecal (in the spine) injection; or
 - intraarticular (in the joint) injection.
17. Any drugs or supplies provided for reduction of obesity or weight, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight.
18. Drugs that the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
19. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
20. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your Employer's group health care plan, or for which benefits have been exhausted.
21. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
22. Supplies for smoking cessation programs and the treatment of nicotine addiction.
23. Compounded drugs that do not meet the definition of Compound Medications in this portion of your Benefit Booklet.
24. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
25. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined by the Plan.
26. Retin A or pharmacologically similar topical drugs.
27. Athletic performance enhancement drugs.
28. Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form.
29. Allergy serum and allergy testing materials.
30. Injectable drugs, except those self-administered subcutaneously or as may be provided under the Specialty Drug Program.
31. Some equivalent drugs manufactured under multiple brand names. BCBSTX may limit benefits to only one of the brand equivalents available. If you do not accept the brand that is covered under this Plan, the Brand Name Drug purchased will not be covered under any benefit level.

32. Replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced.
33. Shipping, handling, or delivery charges.
34. Drugs that are repackaged by anyone other than the original manufacturer.
35. Prescription Orders written by a member of your immediate family, or a self-prescribed Prescription Order.

Definitions

*(In addition to the applicable terms provided in the **DEFINITIONS** Section of the Benefit Booklet, the following terms will apply specifically to this **PHARMACY BENEFITS** section.)*

Allowable Amount means the maximum amount determined by the Claims Administrator to be eligible for consideration of payment for a particular Covered Drug.

1. As applied to Participating Pharmacies and, the Mail-Order Program and Preferred Specialty Drug Providers, the Allowable Amount is based on the provisions of the contract between BCBSTX and the Participating Pharmacy or Pharmacy for the Mail-Order Program or the Preferred Specialty Drug Provider in effect on the date of service.
2. As applied to non-Participating Pharmacies, the Allowable Amount is based on the Participating Pharmacy contract rate.

Brand Name Drug means a drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand Name Drug. There may also be situations where a drug's classification changes from generic to brand name due to a change in the market resulting in the generic being a single source, or the drug product database information changing, which would result in a corresponding change in payment obligations from generic to brand name.

Compound Medications means those drugs that meet the following requirements:

1. The drugs in the compounded product are FDA approved;
2. The approved product has an assigned National Drug Code (NDC); and
3. The primary active ingredient is a Covered Drug under your Pharmacy Benefits.

Copayment Amount, with respect to your Pharmacy Benefits, means the dollar amount paid by the Participant for each Prescription Order filled or refilled through a Participating Pharmacy, non-Participating Pharmacy, the Mail-Order Program, or through the Specialty Pharmacy Program.

Covered Drugs means any Legend Drug (including insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, with disposable syringes and needles needed for self-administration):

1. Which is Medically Necessary and is ordered by a Physician or authorized Health Care Practitioner naming a Participant as the recipient;
2. For which a written or verbal Prescription Order is provided by a Physician or authorized Health Care Practitioner;
3. For which a separate charge is customarily made;
4. Which is not entirely consumed at the time and place that the Prescription Order is written;
5. For which the FDA has given approval for at least one indication; and
6. Which is dispensed by a Pharmacy and is received by the Participant while covered under the Plan, **except when** received from a Provider's office, or during confinement while a patient in a hospital or other acute care institution or facility (refer to **Limitations and Exclusions**).

Generic Drug means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Covered Drugs and corresponding Participant payment responsibility, BCBSTX utilizes the generic/brand status assigned by a nationally recognized provider of drug product database information. A list of Generic Drugs is available on the BCBSTX website at www.bcbstx.com. You may also contact Customer Service at the toll-free number shown in this Benefit Booklet or on your Identification Card for more information.

Health Care Practitioner means an Advanced Practice Nurse, Doctor of Medicine, Doctor of Dentistry, Physician Assistant, Doctor of Osteopathy, Doctor of Podiatry, or other licensed person with prescription authority.

Legend Drugs means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution – Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

National Drug Code (NDC) means a national classification system for the identification of drugs.

Non-Preferred Brand Name Drug means a Brand Name Drug which does not appear on the *Preferred Drug List*.

Participant means an Employee or Dependent whose coverage has become effective under this Plan.

Participating Pharmacy means an independent retail Pharmacy, chain of retail Pharmacies, mail-order Pharmacy, or Specialty Drug Pharmacy which has entered into a written agreement with BCBSTX to provide pharmaceutical services to Participants under the Plan.

Pharmacy means a state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

Preferred Brand Name Drug means a Brand Name Drug which appears on the *Preferred Drug List*.

Prescription Order means a written or verbal order from a Physician or authorized Health Care Practitioner to a pharmacist for a drug or device to be dispensed. Orders written by Physicians or authorized Health Care Practitioners located outside the United States to be dispensed in the United States are not covered under the Plan.

Specialty Drug means a high cost prescription drug that meets any of the following criteria:

1. It is used in limited patient populations or indications;
2. It is typically self-injected;
3. It may have limited availability, or require special dispensing, or delivery and/or patient support is required and, as a result, are difficult to obtain via traditional Pharmacy channels;
4. It has complex reimbursement procedures; or
5. A considerable portion of its use and costs are frequently generated through office-based medical claims.

GENERAL PROVISIONS

Agent

The Employer is not the agent of the Claims Administrator.

Amendments

The Plan may be amended or changed at any time by agreement between the Employer and the Claims Administrator. No notice to or consent by any Participant is necessary to amend or change the Plan.

Assignment and Payment of Benefits

Rights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided.

In the absence of a written agreement with a Provider, the Claims Administrator reserves the right to make benefit payments to the Provider or the Employee, as the Claims Administrator elects. Payment to either party discharges the Plan's responsibility to the Employee or Dependents for benefits available under the Plan.

Claims Liability

BCBSTX, in its role as Claims Administrator, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Disclosure Authorization

If you file a claim for benefits, it will be necessary that you authorize any health care Provider, insurance carrier, or other entity to furnish the Claims Administrator all information and records or copies of records relating to the diagnosis, treatment, or care of any individual included under your coverage. If you file claims for benefits, you and your Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

Medicare

Special rules apply when you are covered by this Plan and by Medicare. Generally, this Plan is a Primary Plan if you are an active Employee, and Medicare is a Primary Plan if you are a retired Employee.

Participant/Provider Relationship

The choice of a health care Provider should be made solely by you or your Dependents. The Claims Administrator does not furnish services or supplies but only makes payment for Eligible Expenses incurred by Participants. The Claims Administrator is not liable for any act or omission by any health care Provider. The Claims Administrator does not have any responsibility for a health care Provider's failure or refusal to provide services or supplies to you or your Dependents. Care and treatment received are subject to the rules and regulations of the health care Provider selected and are available only for sickness or injury treatment acceptable to the health care Provider.

The Claims Administrator, Network Providers, and/or other contracting Providers are independent contractors with respect to each other. The Claims Administrator in no way controls, influences, or participates in the health care treatment decisions entered into by said Providers. The Claims Administrator does not furnish medical, surgical, hospitalization, or similar services or supplies, or practice medicine or treat patients. The Providers, their employees, their agents, their ostensible agents, and/or their representatives do not act on behalf of BCBSTX nor are they employees of BCBSTX.

Refund of Benefit Payments

If the Claims Administrator pays benefits for Eligible Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error, the Plan has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, the Claims Administrator may deduct any refund due it from any future benefit payment.

Subrogation

If the Plan pays or provides benefits for you or your Dependents, the Plan is subrogated to all rights of recovery which you or your Dependent have in contract, tort, or otherwise against any person, organization, or insurer for the amount of benefits the Plan has paid or provided. That means the Plan may use your rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer.

For the purposes of this provision, *subrogation* means the substitution of one person or entity (the Plan) in the place of another (you or your Dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

Right of Reimbursement

In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, the Plan will have a right of reimbursement.

If you or your Dependent recover money from any person, organization, or insurer for an injury or condition for which the Plan paid benefits, you or your Dependent agree to reimburse the Plan from the recovered money for the amount of benefits paid or provided by the Plan. That means you or your Dependent will pay to the Plan the amount of money recovered by you through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the Plan.

Right to Recovery by Subrogation or Reimbursement

You or your Dependent agree to promptly furnish to the Plan all information which you have concerning your rights of recovery from any person, organization, or insurer and to fully assist and cooperate with the Plan in protecting and obtaining its reimbursement and subrogation rights. You, your Dependent or your attorney will notify the Plan before settling any claim or suit so as to enable us to enforce our rights by participating in the settlement of the claim or suit. You or your Dependent further agree not to allow the reimbursement and subrogation rights of the Plan to be limited or harmed by any acts or failure to act on your part.

Coordination of Benefits

The availability of benefits specified in This Plan is subject to Coordination of Benefits (COB) as described below. This COB provision applies to This Plan when a Participant has health care coverage under more than one Plan.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan shall not be reduced when This Plan determines its benefits before another Plan; but may be reduced when another Plan determines its benefits first.

Coordination of Benefits – Definitions

1. **Plan** means any group insurance or group-type coverage, whether insured or uninsured.
This includes:
 - a. group or blanket insurance;
 - b. franchise insurance that terminates upon cessation of employment;
 - c. group hospital or medical service plans and other group prepayment coverage;
 - d. any coverage under labor-management trustee arrangements, union welfare arrangements, or employer organization arrangements;
 - e. governmental plans, or coverage required or provided by law.

Plan does *not* include:

- a. any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;
- b. a policy of health insurance that is individually underwritten and individually issued;
- c. school accident type coverage; or
- d. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

2. **This Plan** means the part of this Benefit Booklet that provides benefits for health care expenses.

3. **Primary Plan/Secondary Plan**

The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the Participant. A *Primary Plan* is a Plan whose benefits are determined before those of the other Plan and without considering the other Plan's benefit. A *Secondary Plan* is a Plan whose benefits are determined after those of a Primary Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the Participant, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

4. **Allowable Expense** means a necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the Participant for whom claim is made.
5. **Claim Determination Period** means a Calendar Year. However, it does not include any part of a year during which a Participant has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.
6. **We or Us** means Blue Cross and Blue Shield of Texas.

Order of Benefit Determination Rules

1. **General Information**

- a. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless (a) the other Plan has rules coordinating its benefits with those of This Plan, and (b) both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.
- b. If this Benefit Booklet contains any dental or vision benefits, the benefits provided by the health portion of This Plan will be the Secondary Plan.

2. **Rules**

This Plan determines its order of benefits using the first of the following rules which applies:

- a. ***Non-Dependent/Dependent.*** The benefits of the Plan which covers the Participant as an Employee, member or subscriber are determined before those of the Plan which covers the Participant as a Dependent. However, if the Participant is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- (1) secondary to the Plan covering the Participant as a Dependent and

- (2) primary to the Plan covering the Participant as other than a Dependent (e.g., a retired Employee), then the benefits of the Plan covering the Participant as a Dependent are determined before those of the Plan covering that Participant other than a Dependent.

- b. ***Dependent Child/Parents Not Separated or Divorced.*** Except as stated in Paragraph c below, when This Plan and another Plan cover the same child as a Dependent of different parents:

- (1) The benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but
- (2) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in this Paragraph b, but instead has a rule based on gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- c. ***Dependent Child/Parents Separated or Divorced.*** If two or more Plans cover a Participant as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

- (1) First, the Plan of the parent with custody of the child;
- (2) Then, the Plan of the spouse of the parent with custody, if applicable;
- (3) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Calendar Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- d. ***Joint Custody.*** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph b.

- e. ***Active/Inactive Employee.*** The benefits of a Plan which covers a Participant as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired Employee. The same would hold true if a Participant is a Dependent of a person covered as a retired Employee and an Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Paragraph e does not apply.

- f. ***Continuation Coverage.*** If a Participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:

- (1) First, the benefits of a Plan covering the Participant as an Employee, member or subscriber (or as that Participant's Dependent);
- (2) Second, the benefits under the continuation coverage.

If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits this Paragraph f does not apply.

- g. ***Longer/Shorter Length of Coverage.*** If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that Participant for the shorter period of time.

Effect on the Benefits of This Plan

1. When This Section Applies

This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this section.

2. **Reduction in this Plan's Benefits**

The benefits of This Plan will be reduced when the sum of:

- a. The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
- b. The benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those Allowable Expenses in a Claim Determination Period.

In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as previously described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

We assume no obligation to discover the existence of another Plan, or the benefits available under the other Plan, if discovered. We have the right to decide what information we need to apply these COB rules. We may get needed information from or release information to any other organization or person without telling, or getting the consent of, any person. Each person claiming benefits under This Plan must give us any information concerning the existence of other Plans, the benefits thereof, and any other information needed to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again.

Right to Recovery

If the amount of the payments We make is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. the persons We have paid or for whom We have paid;
2. insurance companies; or
3. Hospitals, Physicians, or Other Providers; or
4. any other person or organization.

Termination of Coverage

The Claims Administrator for the Plan is not required to give you prior notice of termination of coverage. The Claims Administrator will not always know of the events causing termination until after the events have occurred.

Termination of Individual Coverage

Coverage under the Plan for you and/or your Dependents will automatically terminate when:

1. Your contribution for coverage under the Plan is not received timely by the Plan Administrator; or
2. You no longer satisfy the definition of an Employee as defined in this Benefit Booklet, including termination of employment; or
3. The Plan is terminated or the Plan is amended, at the direction of the Plan Administrator, to terminate the coverage of the class of Employees to which you belong; or
4. A Dependent ceases to be a Dependent as defined in the Plan.

However, when any of these events occur, you and/or your Dependents may be eligible for continued coverage. See **Continuation of Group Coverage – Federal** in the **GENERAL PROVISIONS** section of this Benefit Booklet.

The Claims Administrator may refuse to renew the coverage of an eligible Employee or Dependent for fraud or intentional misrepresentation of a material fact by that individual.

Coverage for a child of any age who is medically certified as *Disabled* and dependent on the parent will not terminate upon reaching the limiting age shown in your Schedule of Coverage if the child continues to be both:

1. *Disabled*, and
2. Dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under the Plan and before the child attains the limiting age. You must submit satisfactory proof of the disability and dependency through your Plan Administrator to the Claims Administrator within 31 days following the child's attainment of the limiting age. As a condition to the continued coverage of a child as a *Disabled* Dependent beyond the limiting age, the Claims Administrator may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Termination of the Group

The coverage of all Participants will terminate if the group is terminated in accordance with the terms of the Plan.

Termination of Benefits

Coverage under the Plan will automatically terminate on the date of termination.

Notice of Creditable Coverage

Upon termination of your coverage under this Plan, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of your or your Dependent's coverage under this Plan.

Continuation of Group Coverage – Federal

See further COBRA details in the **NOTICES** section of this Benefit Booklet.

COBRA Continuation – Federal

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Participants may have the right to continue coverage after the date coverage ends. Participants will not be eligible for COBRA continuation if the Employer is exempt from the provisions of COBRA.

Minimum Size of Group

The Group must have normally employed more than twenty (20) employees on a typical business day during the preceding Calendar Year. This refers to the number of full-time and part-time employees employed, not the number of employees covered by a Health Benefit Plan.

Loss of Coverage

If coverage terminates as the result of termination (other than for gross misconduct) or reduction of employment hours, then the Participant may elect to continue coverage for eighteen (18) months from the date coverage would otherwise cease.

A covered Dependent may elect to continue coverage for thirty-six (36) months from the date coverage would otherwise cease if coverage terminates as the result of:

1. divorce from the covered Employee,
2. death of the covered Employee,
3. the covered Employee becomes eligible for Medicare, or
4. a covered Dependent child no longer meets the Dependent eligibility requirements.

COBRA continuation under the Plan ends at the earliest of the following events:

1. The last day of the eighteen (18) month period for events which have a maximum continuation period of eighteen (18) months.
2. The last day of the thirty-six (36) month period for events which have a maximum continuation period of thirty-six (36) months.
3. The first day for which timely payment of contribution is not made to the Plan with respect to the qualified beneficiary.
4. The Group Health Plan is canceled.
5. The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other group health plan.
6. The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare benefits.

Extension of Coverage Period

The eighteen (18) month coverage period may be extended if an event which could otherwise qualify a Participant for the thirty-six (36) month coverage period occurs during the eighteen (18) month period, but in no event may coverage be longer than thirty-six (36) months from the initial qualifying event.

If a Participant is determined to be disabled as defined under the Social Security Act and the Participant notifies the Employer before the end of the initial eighteen (18) month period, coverage may be extended up to an additional eleven (11) months for a total of twenty-nine (29) months. This provision is limited to Participants who are disabled at any time during the first sixty (60) days of COBRA continuation and only if the qualifying event is termination of employment (other than for gross misconduct) or reduction of employment hours.

Notice of COBRA Continuation Rights

The Employer is responsible for providing the necessary notification to Participants as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

For additional information regarding your rights under COBRA continuation, refer to the Continuation Coverage Rights Notice in the **NOTICES** section of this Benefit Booklet.

Information Concerning Employee Retirement Income Security Act of 1974 (ERISA)

If the Health Benefit Plan is part of an “employee welfare benefits plan” and “welfare plan” as those terms are defined in ERISA:

1. The Plan Administrator will furnish summary plan descriptions, annual reports, and summary annual reports to you and other plan participants and to the government as required by ERISA and its regulations.
2. The Claims Administrator will furnish the Plan Administrator with this Benefit Booklet as a description of benefits available under this Health Benefit Plan. Upon written request by the Plan Administrator, the Claims Administrator will send any information which the Claims Administrator has that will aid the Plan Administrator in making its annual reports.
3. Claims for benefits must be made in writing on a timely basis in accordance with the provisions of this Health Benefit Plan. Claim filing and claim review health procedures are found in the **CLAIM FILING AND APPEALS PROCEDURES** section of this Benefit Booklet.
4. BCBSTX, as the Claims Administrator is not the ERISA “Plan Administrator” for benefits or activities pertaining to the Health Benefit Plan.
5. This Benefit Booklet is not a Summary Plan Description.
6. The Plan Administrator has given the Claims Administrator the authority and discretion to interpret the Health Benefit Plan provisions and to make eligibility and benefit determinations. The Plan Administrator has full and complete authority and discretion to make decisions regarding the Health Benefit Plan’s provisions and determining questions of eligibility and benefits. Any decisions made by the Plan Administrator shall be final and conclusive.

AMENDMENTS

NOTICES

NOTICE

This group health plan believes this plan is a “grandfathered health plan” under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your Employer or the Plan Administrator.

If your group health plan is subject to the Employee Retirement Income Security Act (ERISA), you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, inquiries may be directed to the U.S. Department of Health and Human Services at www.healthreform.gov.

NOTICE

Other Blue Cross and Blue Shield Plans Separate Financial Arrangements with Providers

BlueCard

Blue Cross and Blue Shield of Texas hereby informs you that other Blue Cross and Blue Shield Plans outside of Texas (“Host Blues”) may have contracts similar to the contracts described above with certain Providers (“Host Blue Providers”) in their service areas.

When you access health care services through BlueCard outside of Texas and from a Provider which does not have a contract with Blue Cross and Blue Shield of Texas, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your covered services, or
- The negotiated price that the Host Blue passes on to Blue Cross and Blue Shield of Texas.

Often, this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that takes into consideration the actual price increased or reduced to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be charged as a billed charge reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, Blue Cross and Blue Shield of Texas would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

NOTICE

The Women's Health and Cancer Rights Act of 1998 requires this notice. This Act is effective for plan year anniversaries on or after October 21, 1998. This benefit may already be included as part of your coverage.

In the case of a covered person receiving benefits under their plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Deductibles, Co-Share and copayment amounts will be the same as those applied to other similarly covered medical services, such as surgery and prostheses.

NOTICE

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN.

NOTICE**CONTINUATION COVERAGE RIGHTS UNDER COBRA**

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of

COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

Information Provided by your Employer

**EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974
PLAN ADMINISTRATION INFORMATION**

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your benefit booklet/Certificate. Your Plan Administrator has determined that this information together with the information contained in your benefit booklet/Certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Blue Cross and Blue Shield is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:

Patterson-UTI Energy, Inc. Cafeteria Plan

Plan Sponsor:

Patterson-UTI Energy, Inc.
4510 Lamesa Hwy.
Snyder, TX 79549

Employer Identification Number:

75-2504748

Plan Administrator:

The Employer is the Plan Administrator. The Plan Administrator is responsible for providing you and other Participants information regarding your rights and benefits under the Plan. The Plan Administrator also must file various reports, forms and returns for the Department of Labor and for the Internal Revenue Services.

Plan Number:

501

Claim Administration:

Claims for benefits should be directed to:
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044901

Type of Plan Administration:

The Plan is commonly referred to as a Cafeteria Plan.

Agent for Service of Legal Process:

The name of the person designated as the Agent for Service of Legal Process is SETH WEXLER, whose address is:
450 Gears Rd.
Suite #500
Houston, TX 77067

Plan Year:

January 1st thru December 31st

Waiting Period:

New hires become eligible the first day of the pay period following 75 days of employment.

Open Enrollment:

November

Funding Arrangements:

The Plan is self-insured by the Employer and the Covered Participants. The Employer has obtained a reinsurance policy with an insurance company for protection against certain large unexpected claims.

Contributions:

Contributions are determined by the Plan Sponsor and include Employer contributions and contributions by Covered Participants.

Eligibility:

The Plan's provisions relating to eligibility are described in detail in the section entitled "Eligibility Requirements".

Benefits and Administration:

The Plan provides Covered Participants with the payment of or reimbursement of certain eligible medical expenses, which are described in detail in the section entitled "Covered Medical Expenses".

Loss of Benefits:**LIMITATION OF LIABILITY**

The Plan Sponsor shall not be obligated to pay any benefits under the Plan for any claim if the proof of loss for such claim was not submitted within the period provided in "Claim Filing" above, except in the case of legal incapacity of the Covered Participant.

LEGAL ACTIONS

Proper written proof of loss must be filed in accordance with the requirements of the Plan. If timely decisions or other ERISA claims procedures regulations fail to be made or followed, a claimant shall be deemed to have exhausted the administrative remedies available under the Plan and shall be entitled to pursue any available remedies under section 502(a) of the Act to enforce their rights.

Termination of Plan or Bankruptcy:

The Plan Sponsor reserves the right to terminate, amend or modify the Plan or any benefits under the Plan, in whole or in part, at any time upon approval by action or resolution approved and adopted by the Plan Sponsor.

How To Get Your Benefits:

This information is explained in the section of the booklet entitled "CLAIMS FILING PROCEDURES."

Claim Review Procedure:

This information is explained in the section of the booklet entitled "REVIEW OF CLAIMS DETERMINATIONS"

Statement of ERISA Rights:

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

- a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- c. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage:

- a. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this booklet and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- b. Reduction or elimination of exclusionary periods of coverage for Preexisting Conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a certificate of Creditable Coverage, free of charge from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a preexisting exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries:

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit under the plan or exercising your rights under ERISA.

Enforce Your Rights:

If your Claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen the plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees.

If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your Claim is frivolous.

Assistance with Your Questions:

If you have any questions about the plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue, N. W., Washington, D. C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA):

Group health plans and health insurance issuers, under USERRA, must protect all persons who perform duty,

voluntarily or involuntarily, in the "uniformed services", which include the Army, Navy, Marine Corps, Air Force, Coast Guard and Public Health Service commissioned corps, as well as the reserve components of each of these services. If you are a pre-service member returning from a period of service in the uniformed services, you are entitled to reemployment from your Employer if you meet the following criteria:

- you held the job prior to service;
- you gave notice to your Employer that you were leaving your employment for service in the uniformed services, unless giving notice was precluded by military necessity or otherwise impossible or unreasonable;
- your cumulative period of service did not exceed five years;
- you were not released from service under dishonorable or other punitive conditions; and
- you reported back to the job in a timely manner or submitted a timely application for reemployment.

The time limits for returning to work are as follows:

- For less than 31 days of service – by the beginning of the first regularly scheduled work period after the end of the calendar day of duty, plus time required to return home safely and an eight hour rest period. If this is impossible or unreasonable through no fault of your own, then as soon as possible;
- For 31 to 180 days of service – you must apply for reemployment no later than 14 days after completion of military service. If this is impossible or unreasonable through no fault of your own, then as soon as possible;
- For 181 days or more of service – you must apply for reemployment no later than 90 days after completion of military service;
- For service-connected injury or illness – reporting or application deadlines are extended for up to two years if you are hospitalized or convalescing.

Aviso Importante:

Para obtener informacion o para someter una queja usted puede llamar al numero de telefono gratis de Blue Cross and Blue Shield of Texas para informacion o para someter una queja al: 1-800-521-2227. Usted tambien puede escribir a Blue Cross and Blue Shield of Texas al: P. O. Box 660044, Dallas, Texas 75266-0044.

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Changing Your Elections

According to IRS rules, you cannot make coverage changes during the year unless you experience a qualifying event.

In general, your benefit elections are irrevocable for the plan year. However, if you experience a change in status that directly affects your eligibility for coverage, then you may generally change your election within 30 days of the qualifying event. Any coverage changes you make must be consistent with your change in status, as described in IRS guidelines. For example, if you get married, you can add your spouse as a dependent to your medical or dental plan coverage.

Qualifying Events that Permit Election Changes for Health Benefits, Life Insurance Benefits, and Disability Benefits include:

Change in marital status: You may elect coverage for yourself and/or your newly acquired married spouse or drop coverage for your former spouse if you divorce, legally separate, or have your marriage annulled or your married spouse dies. For this purpose, the word “married” means only a legal union between one man and one woman as husband and wife, and the word “spouse” refers only to a person of the opposite sex who is a husband or a wife.

Birth or adoption of dependent child: You may elect coverage for your newborn, adopted child or a child placed with you for adoption; you may drop coverage if a dependent child dies, or if he or she ceases to be eligible under the plan.

Change in employment status: You may add or drop coverage consistent with a change in employment status of you, your spouse or dependents that affect the benefit eligibility under this plan or under the employee benefit plan of your spouse or dependents. You, your spouse or dependent experience a change in employment status when any of the following occur: begin or end employment, take part in a strike or lockout, begin or return from an approved leave of absence, switch from hourly to salaried, switch from union to non-union or vice versa, reduce or increase the number of hours you work or any similar change that affects your eligibility under the Plan.

Dependent eligibility: You may add or drop your dependent in the event he or she becomes or ceases to be eligible under the Plan.

Change in residence: You may change your coverage option if you move and it affects your benefit availability.

Additional Status Change Events that Permit Election Changes for Health Benefits Only:

- Family and Medical Leave Act (FMLA) – Certain election changes are permitted when you start an FMLA leave and when you return from an FMLA leave.
- Judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a “qualified medical child support order” or QMCSO) that requires health coverage for an employee’s child or foster child.
- You, your spouse or your dependent become entitled to or lose eligibility for Medicare or Medicaid.
- You, your spouse or dependent gain eligibility under another employer’s plan.
- A significant change in your benefit cost or coverage.
- A change in status that results in a “special enrollment right” under the Health Insurance Portability and Accountability Act (HIPAA).
- Effective as of April 1, 2010, if you or your dependents are covered under Medicaid or the Children’s Health Insurance Program (“CHIP”) and such coverage is terminated, or you or your dependent become eligible for a state subsidy for enrollment in a health plan under Medicaid or CHIP, then you may request coverage under the Plan within 60 days after such termination or eligibility.

Any coverage changes you make must be consistent with your qualified change in status as described in IRS guidelines. For example, if you get married, you can add your spouse as a dependent to your medical or dental plan coverage, unless your spouse is eligible for medical coverage through his/her employer. However, you cannot normally change the medical or dental plan option in which you have enrolled.

You must complete a Benefits Enrollment/Change Form and return it to the Patterson-UTI Energy Plan Administrator within the applicable (30) days of the status change (60 days for a CHIP related status change). If you miss this 30-day period, you will not be able to change your coverage until the following annual enrollment period, unless you have another change in status that affects your eligibility under the plan. You may also be required to complete additional forms for approval and/or to determine eligibility, such as an Evidence of Insurability form.

Family and Medical Leave Act

If you have worked for the company at least 1,250 hours over the previous 12-month period, and have at least 12 months of service, you may be eligible for up to 12 weeks of unpaid leave under the Family and Medical Leave Act ("FMLA"). You may request a Family and Medical Leave of Absence:

- After the birth or adoption of your child or if a child is placed with you for adoption or foster care.
- To care for your spouse, child or parent who has a serious health condition. **OR**
- If you have a serious health condition that makes you unable to perform your job.

During FMLA leave, your Medical coverage and other benefits offered through the Plan will continue on the same basis as if you had continued working. You may change your benefit election when you go out on FMLA leave and again when you return to work. You must continue to pay your share of the cost for your benefits coverage during a leave of absence or disability. If your leave is unpaid, you are responsible for paying the premiums. If you fail to make a premium payment, your coverage may be terminated. If your coverage terminated while you were on FMLA leave, your coverage will resume if you re-enroll when you return from FMLA leave. Upon your return from leave, any unpaid premiums will be deducted from your payroll in one lump sum. If the leave continues beyond 12 weeks, the leave of absence guidelines will apply. Of course, any changes in the Plan's terms, rules or practices that go into effect while you are away on FMLA leave, apply to you and your dependents in the same manner as to active employees and their dependents.

Continuation of benefits coverage for personal medical reasons will be extended for at least 12 weeks. Further extension of coverage will be determined in accordance with the Plan's Leave of Absence guidelines. For more information regarding the FMLA and the Leave of Absence guidelines, please contact Human Resources or the Plan Administrator.

Mental Health Parity Act of 1996

The Plan is intended to comply with the Mental Health Parity Act of 1996 ("MHPA"). The annual and lifetime dollar limits applicable to mental health benefits will not be less than the annual and lifetime dollar limits applicable to other types of medical and surgical services. The Plan also intends to comply with the Mental Health Parity & Equity Act of 2008. As a consequence, effective as of August 1, 2010, the Plan will ensure that the same financial requirements (co-pays, deductibles, co-insurance) that apply to medical/surgical benefits are applied to mental health and substance abuse disorder benefits; and (2) that treatment limitations (number of visits, days of coverage) for mental health and substance abuse disorder benefits are no more restrictive than those which apply to medical/surgical benefits.

Newborns and Mothers Health Protection Act of 1996

The Plan is intended to comply with all required provisions of the Newborn's and Mother's Health Protection Act of 1996 ("NMHPA") with respect to health benefits provided under the Plan. The Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section delivery. You only need to pre-certify maternity hospital stays if the hospital stay will be longer than the periods specified above. However, you must still pre-certify any hospital admission during your pregnancy that is not due to delivery or is in excess of the applicable timeframes outlined above. In addition, the Plan will not require that a provider obtain authorization from the Plan or the insurance company for prescribing a length of stay not in excess of the above periods. However, the NMHPA generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Women's Health and Cancer Rights of 1998

The Plan intended to comply with the Women's Health and Cancer Rights Act of 1998, which requires that all health insurance plans that cover mastectomy also cover the following medical care:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and/or
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Such coverage will be provided in a manner determined in consultation with the physician and patient. To the extent permitted by applicable law, the coverage is subject to all the terms of the plan, including applicable *deductibles*, *benefit maximum allowances*, *copayments* and *co-insurance* provisions.

Keep Your Plan Administrator Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Amendment and Termination

Patterson-UTL Energy, Inc. expects and intends to continue each of the benefit plans indefinitely. The company, however, reserves the right to amend, modify, suspend, increase the cost of or terminate any of the plans at any time in its sole discretion, in accordance with applicable laws and any collective bargaining agreements.

Note: Claims arising before the date of termination would be reviewed and honored if the plan administrator determines such claims are valid.

Qualified Medical Child Support Order (QMCSO)

If the Plan Administrator receives a court order to provide medical coverage for an Eligible Employee's natural or adopted child, the Plan Administrator must notify the employee and determine if the child is eligible for coverage under this Plan. Eligibility determinations will be made in accordance with federal and/or state child support laws. The Eligible Employee will be responsible for any contributions required under this Plan.

The coverage provided in accordance with a QMCSO will be effective as of the date of the child support order and subject to all provisions of the Plan except:

1. A qualified dependent may be covered without the employee's personal coverage in effect under this plan.
2. Any child of a Plan Participant who is an alternate recipient under a QMCSO shall be considered as having a right to Dependent Coverage under this Plan with no Pre-existing Condition Provisions applied.

In addition to the reasons for termination of coverage shown in the Termination of Coverage Provision, the coverage required by a QMCSO will cease on the earlier of the date the support order expires or the date the dependent is enrolled for similar coverage, whichever is earlier.

If Eligible Expenses for an Eligible Dependent child covered under this provision are paid by a custodial parent or legal guardian who is not a Plan member, benefits will be paid directly to the custodial parent or legal guardian rather than the Eligible Employee. A custodial parent or legal guardian may also sign claim forms and assign Plan benefits.

Military Leave Act

Eligible Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA). These rights include up to a maximum of 24 months of continued health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage with no Pre-existing Condition exclusion applied by the Plan upon return from military service. These rights apply only to Covered Persons covered under the Plan before leaving for military service. Plan exclusions and Waiting Periods may be imposed for any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

**Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free Or Low-Cost Health Coverage To Children And Families**

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment"

opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of March 3, 2010. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	COLORADO – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone: 1-800-866-3513 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP	
Website: http://www.azahcccs.gov/applicants/default.aspx Phone: 602-417-5422	
ARKANSAS – CHIP	FLORIDA – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-866-762-2237
GEORGIA – Medicaid	MONTANA – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084
IDAHO – Medicaid and CHIP	NEBRASKA – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 208-334-5747 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
INDIANA – Medicaid	NEVADA – Medicaid and CHIP
Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
IOWA – Medicaid	
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: https://www.khpa.ks.gov	Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm
Phone: 800-766-9012	Phone: 1-800-852-3345 x 5254
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-635-2570	Medicaid Phone: 1-800-356-1561
LOUISIANA – Medicaid	CHIP Website: http://www.njfamilycare.org/index.html
Website: www.dhh.louisiana.gov/offices/?ID=92	CHIP Phone: 1-800-701-0710
Phone: 1-888-342-6207	
MAINE – Medicaid	NEW MEXICO – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html
Phone: 1-800-321-5557	Medicaid Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico
Medicaid & CHIP Website: http://www.mass.gov/MassHealth	CHIP Phone: 1-888-997-2583
Medicaid & CHIP Phone: 1-800-462-1120	
MINNESOTA – Medicaid	NEW YORK – Medicaid
Website: http://www.dhs.state.mn.us/	Website: http://www.nyhealth.gov/health_care/medicaid/
Click on Health Care, then Medical Assistance	Phone: 1-800-541-2831
Phone: 800-657-3739	
MISSOURI – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm	Website: http://www.nc.gov
Phone: 573-751-6944	Phone: 919-855-4100
NORTH DAKOTA – Medicaid	UTAH – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/	Website: http://health.utah.gov/medicaid/
Phone: 1-800-755-2604	Phone: 1-866-435-7414
OKLAHOMA – Medicaid	VERMONT – Medicaid
Website: http://www.insureoklahoma.org	Website: http://ovha.vermont.gov/
Phone: 1-888-365-3742	Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.oregon.gov/DHS/healthplan/index.shtml	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm
Medicaid Phone: 1-800-359-9517	Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.oregon.gov/DHS/healthplan/app_benefits/ohp4u.shtml	CHIP Website: http://www.famis.org/
CHIP Phone: 1-800-359-9517	CHIP Phone: 1-866-873-2647

PENNSYLVANIA – Medicaid	WASHINGTON – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-877-543-7669
RHODE ISLAND – Medicaid	WEST VIRGINIA – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	WISCONSIN – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program since March 3, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

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Notice of Privacy Practices for Protected Health Information

This Notice describes how “protected health information” (“PHI”) about you may be used and disclosed by the Plan, your legal rights regarding your PHI held by the Plan, and how you can get access to this information. Please review this notice carefully.

THE PLAN’S DUTIES

1. **Safeguard the Privacy of your Protected Health Information:** Federal law requires that the Plan safeguard the privacy of your “protected health information” or PHI. PHI includes all individually identifiable health information created or received by the Plan relating to your past, present, or future physical or mental health condition, treatment of/for that condition, or payment for the treatment of healthcare. PHI includes such information maintained by the Plan in oral, written or electronic form.
2. **Notification of the Plan’s Privacy Policies:** Federal law requires that the Plan notify you of its legal duties and privacy policies and procedures with respect to your PHI. This Notice is intended to satisfy this requirement.
3. **Use and Disclose your PHI Only as Described in this Notice:** The Plan will abide by the terms of this Notice as long as it remains in effect. Under the law and as described in this notice the Plan may use and disclose your PHI without first obtaining your written authorization, consent, or without giving you the opportunity to agree or object. If the Plan obtains your written authorization for a use or disclosure not described in this Notice, you may revoke that authorization at any time by submitting the appropriate form to the HIPAA Privacy and Security Officer. The HIPAA Privacy and Security Officer will provide you with a copy of the appropriate form upon request.

How the Plan May Use and Disclose Your PHI :

1. **Uses and Disclosures for Treatment:** The Plan may use and disclose your PHI for “treatment.” Treatment includes the provision, coordination, or management of healthcare and related services by one or more health care providers, including, but not limited to, the referral of a patient from one health care provider to another. Providers include without limitation doctors, nurses, pharmacists, technicians, medical students or other hospital personnel who are involved in taking care of you. For example, the Plan might use your PHI to provide information to your internist concerning specialists within the network to whom you can be referred for a specific type of treatment.
2. **Uses and Disclosures for Payment:** The Plan will use and disclose your PHI for “payment.” Payment includes, but is not limited to, claims processing, claims payment, payroll deductions, coordinate plan coverage, and eligibility determinations. For example, the Plan may use your PHI to determine whether you are entitled to benefits and, if you are, to prepare a check to reimburse you.
3. **Uses and Disclosures for Health Care Operations:** The Plan will use and disclose your PHI for “health care operations.” Health care operations include, but are not limited to, securing or placing a contract for reinsurance of risk relating to claims for health care; arranging for medical review, legal services, auditing functions, and fraud and abuse detection programs; business planning and development, investigating and resolving complaints of privacy violations, responding to inquiries from the Department of Health and Human Services (HHS); and business management and general administrative activities. For example, the Plan may review your PHI to determine whether it must produce the PHI in response to a request by HHS.
4. **Disclosures to the Plan Sponsor:** The sponsor of the Plan is Patterson-UTI Energy, Inc. The Plan will disclose your PHI to the Company’s in-house administrators so that they can perform “plan administration functions.” Plan administration functions include, but are not limited to, claims processing, eligibility, determinations, and appeals from denials of coverage. The Company’s in-house administrators are prohibited from using or disclosing your PHI for employment-related decisions. Accordingly, the company’s in-house administrators will only disclose your PHI as necessary to perform Plan administrative functions or as otherwise required by HIPPA, unless you have authorized further disclosures.
5. **Disclosures to Business Associates:** The Plan has contracted with third parties (referred to as business associates) to use and disclose your PHI to perform services for the Plan. The Plan will disclose your PHI to a business associate only after securing the business associate’s written agreement to safeguard the privacy of your PHI.

How the Plan Might Use or Disclose Your PHI Without Your Authorization

1. **Plan administration functions of payment and health care operations:** The Plan may use or disclose your PHI for: enrollment, underwriting, and premium rating; premium payment, claims processing, obtaining payment under a contract of reinsurance, eligibility determinations, and claims adjudication; reviewing plan performance and creating, renewing, or replacing an insurance contract, ceding, securing, or placing a contract for reinsurance of risk related to health care claims; fraud and abuse detection, and contracting for legal services or auditing functions on the Plan’s behalf.
2. **Uses or Disclosures Required by Law:** The Plan may use or disclose your PHI as required by any statute, regulation, court order, or other mandate enforceable in a court of law.
3. **Disclosures for Work-Related Injuries:** The Plan may disclose your PHI as required or permitted by applicable State or Federal laws.

4. **Disclosures To Family Members or Close Personal Friends:** The Plan may disclose your PHI to a family member or close personal friend who is involved in your treatment or payment for your treatment if (a) you are present and agree to the disclosure; or (b) you are not present, but applicable State and/or Federal law permits or requires disclosure.
5. **Disclosures for Judicial and Administrative Proceedings:** The Plan may disclose your PHI in an administrative or judicial proceeding in response to a subpoena court order, warrant, summons or a request to produce documents. The Plan will disclose your PHI in these circumstances only if the requesting party first provides the Plan with written documentation that the privacy of your PHI will be protected.
6. **Disclosures for Law Enforcement Purposes:** The Plan may disclose your PHI for law enforcement purposes to a law enforcement official, such as in response to a grand jury subpoena court order, warrant or summons. Before producing your PHI for law enforcement purposes, the Plan will take steps to ensure the nature and the legitimacy of the request.
7. **Incidental Uses and Disclosures:** The Plan may use or disclose your PHI in a manner that is incidental to the uses and disclosures described in this Notice.
8. **Disclosures For Public Health Activities:** The Plan may disclose your PHI to a government agency responsible for preventing or controlling disease, injury, disability, child abuse or neglect. The Plan may disclose your PHI to a person or entity regulated by the Food and Drug Administration (FDA) if the disclosure relates to the quality or safety of an FDA-regulated product, such as a medical device.
9. **Disclosure For Health Oversight Activities:** The Plan may disclose your PHI to a government agency responsible for overseeing health care systems or health-related government benefit programs.
10. **Disclosures about Victims of Abuse, Neglect, or Domestic Violence:** The Plan may disclose your PHI to the responsible government agency if the Plan (a) reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) is required or permitted by law to make the disclosure. The Plan will promptly inform you that such a disclosure has been made, unless the Plan determines that informing you or your personal representative would not be in your best interest.
11. **Uses and Disclosures to Avert a Serious Threat to Health or Safety:** The Plan may use or disclose your PHI to reduce a risk of serious and imminent harm to another person or to the public.
12. **Disclosures to HHS:** The Plan may disclose your PHI to HHS, the government agency responsible for overseeing compliance with federal privacy laws and regulations.
13. **Disclosures for Research:** The Plan may use or disclose your PHI for "research," subject to conditions. Research means systemic investigation designed to contribute to generalized knowledge.
14. **Disclosures In Connection With Your Death or Organ Donation:** The Plan may disclose your PHI to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ donor procurement organization to facilitate transplantation of an organ.

Your Privacy Rights As A Participant in the Plan

1. **Right to Review Your PHI:** You may make a written request to the HIPAA Privacy and Security Officer to review your PHI on file with the Plan. The HIPAA Privacy and Security Officer will arrange for your review within 30 days of your request, unless the PHI is not available on-site, in which case the review will occur within 60 days of your request. The Plan may extend the deadline by up to an additional 30 days.
2. **Right to Receive Photocopies of your PHI:** You may request photocopies of your PHI on file with the Plan by submitting the appropriate form to the HIPAA Privacy and Security Officer. The Plan will mail photocopies to you within 30 days of your request, unless the PHI is not available on-site, in which case the Plan will mail the photocopies within 60 days of your request. The Plan may extend the deadline for mailing up to 30 days. The Plan may charge you a reasonable, cost-based fee for photocopies or for mailing. If there is a charge, the HIPAA Privacy and Security Officer will first contact you to determine whether you wish to modify or withdraw your request.
3. **Right to Amend PHI:** If you feel that your PHI held by the Plan is incorrect or incomplete, you have the right to request an amendment of your PHI on file with the Plan by submitting the appropriate request form to the HIPAA Privacy and Security Officer. The Plan will respond to your request within 60 days. The Plan may extend the deadline by up to an additional 30 days. If the Plan denies your request to amend, the Plan will provide a written explanation of the denial. You would then have 30 days to submit a written statement explaining your disagreement with the denial. Your statement of disagreement would be included with any future disclosure of the disputed PHI.
4. **Right to an Accounting of Disclosures of Your PHI:** You may request an accounting of the disclosures of your PHI by submitting the appropriate form to the HIPAA Privacy and Security Officer. The Plan will provide the accounting within 60 days of your request. The Plan may extend the deadline by up to an additional 30 days. The accounting will exclude the following disclosures: (a) disclosures for treatment, payment, or health care operations, (b) disclosures to you or pursuant to your authorization, (c) incidental disclosures, (d) disclosures made to your family members in your presences or because of an emergency (e) disclosures for national security purposes (f) and disclosures made before April 14, 2003. The Plan will provide the first accounting during any 12-month period without charge. The Plan may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there is a charge, the HIPAA Privacy and Security Officer will first contact you to determine whether you wish to modify or withdraw your request.

5. **Right to Request Additional Restrictions on the Use or Disclosure of your PHI:** You may request that the Plan place restrictions on the use or disclosure of your PHI for treatment, payment, or for health care operations in addition to the restrictions required by federal laws by submitting the appropriate request form to the HIPAA Privacy and Security Officer. The Plan will notify you in writing within 30 days of your request whether it will agree to the requested restriction. The Plan is not required to agree with your request.
6. **Right to Request Communication by Alternative Means or to an Alternative Location:** The Plan will honor your reasonable request to receive PHI by alternative means, or at an alternative location, if you submit to the HIPAA Privacy and Security Officer a signed statement that the delivery of PHI by mail to the address listed in the Plan's record could endanger you.
7. **Right to a Paper Copy of this Notice:** You may request a paper copy of this Notice from the HIPAA Privacy and Security Officer at any time.

A Note About Personal Representatives

Your personal representative may exercise all of the rights described above after the personal representative has provided the Plan with proof of his or her authority to act on your behalf. Proof of authority may be established by (a) a power of attorney for health care purposes notarized by a notary public, (b) a court order appointing the person to act on your behalf as your conservator or guardian, or (c) any other document which the Plan, in its sole and absolute discretion, deems appropriate. Under the HIPAA privacy rule, the Plan does not have to disclose PHI to a personal representative if it has reason to believe that: 1) You have been or maybe subjected to domestic violence, abuse or neglect by such person; or 2) Treating such person as your personal representative could endanger you; and 3) it is not in your best interest to treat such person as your personal representative.

Your Right to File a Complaint

If you believe that your privacy rights have been violated because the Plan has used or disclosed your PHI in a manner inconsistent with this Notice, because the Plan has not honored your rights as described in this Notice, or for any other reason, you may file a complaint in one, or both, of the following ways:

1. **Internal Complaint:** Within 180 days of the date you learned of the conduct, you can submit a complaint form to the HIPAA Privacy and Security Officer, Benefits Department, P.O. Box 1416, Snyder, Texas 79550. You can obtain a Request for Investigation/Complaint Form from the HIPAA Privacy and Security Officer or from the Human Resources Department by calling (325) 574-6385. The HIPAA Privacy and Security Officer will investigate your complaint and mail a decision to you within 90 days of the date of your complaint.
2. **Complaint to HHS:** You may submit a complaint by mail to the U.S. Department of Health and Human Services, Office for Civil Rights, 1301 Young Street, Suite 1169, Dallas, TX 75202.

The Plan's Anti-Retaliation Policy

The Plan will not retaliate against you for submitting an internal complaint, a complaint to HHS, or for exercising your other rights as described in this Notice or under applicable law.

Whom to Contact For More Information about the Plan's Privacy Policies and Procedures

If you have any questions about this Notice, or about how to exercise any of the rights described in this Notice, you should contact the Plan's HIPAA Privacy and Security Officer, P.O. Box 1416, Snyder, Texas 79550. You may also call at (325) 574-6385.

Revisions to the Privacy Policy and to the Notice

The Plan has the right to change this Notice or the Plan's privacy policies and procedures at any time. If the change to the Plan's privacy policies and procedures would have a material impact on your rights, the Plan will notify you of the change by promptly mailing to you a revised Notice that reflects the change. Any change to the Plan's privacy policies and procedures, or to the Notice, will apply to your PHI created or received before the revision.

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Important Notice from PATTERSON-UTI ENERGY, INC.
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with PATTERSON-UTI ENERGY, INC and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- 2. PATTERSON-UTI ENERGY, INC has determined that the prescription drug coverage offered by PATTERSON-UTI ENERGY, INC is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current **PATTERSON-UTI ENERGY, INC** coverage will not be affected. You may enroll in a Medicare drug plan as a supplement to, or in lieu of, other coverage. If you do decide to join a Medicare drug plan and drop your current **PATTERSON-UTI ENERGY, INC** coverage, be aware that you and your dependents may not be able to get this coverage back until the following open enrollment period or when you experience a HIPAA special enrollment event.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with **PATTERSON-UTI ENERGY, INC** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage

Contact the **PATTERSON-UTI ENERGY, INC BENEFITS DEPARTMENT** for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug

plan, and if this coverage through **PATTERSON-UTI ENERGY, INC** changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

From: Patterson-UTI Energy, Inc.
 Date: January 1st, 2012
 Contact: Benefits Department
 Address: PO BOX 1416
 Snyder, Texas 79550
 Phone: (325) 574 -6385



BlueCross BlueShield of Texas



bcbstx.com

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EXHIBIT C

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ADMINISTRATIVE FACTS

This section contains administrative facts about all of the plans under the Schneider Electric Benefit Program for U.S. Employees such as:

- Claims review
- How to appeal if your claim is denied
- HIPAA privacy and security rules
- Statement of your rights under federal law (including ERISA)
- Administrative information about the Plans
- Information about insurance certificates

If you do not understand something in this section or if you need assistance to appeal a claim, please contact PeopleLink.

Claims Review

Timeline for Health Care Claims Review

The claims procedures described in this section apply to the following health care plans:

- Medical
 - Core PPO
 - Buy-up PPO
 - EPO
 - High Deductible Health Plan (HDHP)
- Prescription Drugs
 - Express Scripts
- Dental
 - Core
 - Buy-up
- Vision
- Health Care Flexible Spending Account (FSA) or Limited Use Health Care FSA

Claims for these benefits fall into one of four categories: post-service, pre-service, urgent care and concurrent. Claims for Plan benefits will be administered by the appropriate claims administrator (see the "**Additional Plan Information**" table at the end of this section).

Post-Service Claims

Post-service claims are claims for benefits that are filed *after* medical care has been received. If your post-service claim is denied, you will receive a written notice from the claims administrator no later than 30 days after the claim was received, as long as all needed information was provided with the claim. Sometimes additional time is necessary to process a claim due to circumstances beyond the control of the Plan. If an extension is necessary, the claims administrator will notify you in writing within the 30-day period of the reasons for the extension and the date by which it expects to render a decision. The extension generally will be no longer than 15 days, unless additional information is needed.

If the extension is necessary because you failed to provide all needed information, the notice of the extension will describe the additional information required. You will have 45 days to provide the additional information. If all the additional information is received within 45 days, the claims administrator will notify you of its claim decision within 15 days after the information is received. If you do not provide the needed information within the 45-day period, the claims administrator may deny the claim.

Pre-Service Claims

Pre-service claims are claims that require notification or approval *prior* to receiving medical care. If your pre-service claim is submitted properly with all of the information necessary, the claims administrator will send you a notice of the benefit determination, whether denied or not, no later than 15 days after it receives the claim.

If you file a pre-service claim that does not meet the Plan's procedures, the claims administrator will notify you of the improper filing and how to correct it within five days after the improper claim is received.

If an extension is necessary to process your pre-service claim, the claims administrator will notify you in writing within the initial 15-day response period, and may request a one-time extension of up to 15 days. If the extension is necessary because you failed to provide all needed information, the notice of the extension will describe the additional information required. You will then have 45 days to provide the additional information. If all the needed information is received within 45 days, the claims administrator will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45-day period, the claims administrator may deny the claim.

Urgent Care Claims

Urgent care claims are claims that require notification or approval prior to receiving medical care and a delay in the care:

- Could seriously jeopardize your life, health or your ability to regain maximum function, or
- In the opinion of a physician with knowledge of your medical condition, could cause severe pain that could not be adequately managed without the care or treatment.

If you file an urgent care claim in accordance with the Plan's procedures and include all needed information, the claims administrator will notify you of the determination, whether denied or not, as soon as possible, but no later than 72 hours after receipt of the urgent claim.

However, if you file an urgent care claim that does not meet the Plan's procedures, the claims administrator will notify you of the improper filing and how to correct it within 24 hours of receipt of the improper claim. This notification may be oral, unless you request a written notification.

If you fail to provide all the information required to decide your urgent claim, the claims administrator will notify you of the additional information needed within 24 hours after it received the claim. You will then have 48 hours to provide the requested information.

You will be notified of the determination on your claim no more than 48 hours after the earlier of:

- The claims administrator's receipt of the requested information, or
- The end of the 48 hours given to you to provide the requested information.

Concurrent Care Claims

There are two types of concurrent care claims:

- A claim to extend coverage for a course of treatment beyond a previously approved period of time or number of treatments, or
- A claim regarding reduction or termination of coverage by the Plan before the end of a previously approved period of time or number of treatments.

You must submit a request to extend an ongoing course of treatment at least 24 hours before the end of the previously approved limit. If your request for extension is timely and involves urgent care, the claims administrator will notify you of the determination, whether denied or not, within 24 hours after the claim is received. If your claim is not made at least 24 hours prior to the end of the previously approved limit, the request will be treated as an urgent care claim (*not* a concurrent care claim) and decided according to the timeframes described above under **"Urgent Care Claims."**

A request to extend coverage that does not involve urgent care will be considered a new claim and will be decided according to the post-service or pre-service timeframes described previously, whichever applies.

If an ongoing course of treatment previously approved by the Plan is cut short for continued coverage, the claims administrator will notify you sufficiently in advance to allow you to submit an appeal before the treatment is reduced or terminated.

Explanation of Denied Claims

If your claim for any pre-service, post-service, urgent care or concurrent care claim is denied, the written explanation of the denial will:

- give the specific reason(s) for the denial, citing applicable plan provisions;
- describe any additional material or information necessary to perfect the claim;
- explain why such information is necessary;
- describe the Plan's appeal procedures and your right to bring a civil action under ERISA Section 502(a) following the denial of an appeal;
- for urgent care claims, describe the expected review process applicable to such claims;
- disclose any internal rule, guideline, protocol, or similar criterion relied on in denying the claim (or a statement that such information will be provided free of charge upon request); and
- if the denial is based on a medical necessity, experimental treatment or similar exclusion, explain the scientific or clinical judgment relied on for the determination (or a statement that such explanation will be provided free of charge upon request).

Notifications regarding urgent care claim determinations may be oral, in which case written or electronic (via e-mail) confirmation will follow within three days.

Questions About Benefit Determinations

If you have questions or concerns about a benefit determination, you may informally contact the claims administrator before requesting a formal appeal. If the customer service representative cannot resolve the issue to your satisfaction over the phone, you may submit your questions in writing. Remember, however, that if you are not satisfied with a benefit determination, you may appeal it immediately as described in the section that follows, without first informally contacting customer service.

The customer service telephone number is shown on your Plan ID card.

Timeline for Other Benefit Plan Claims Review

If you file a claim for benefits (other than health care and disability benefits) and it is denied, you will be notified within 90 days of the date the claim is received. However, in special situations, the Plan Administrator or insurance company may need an extension (up to another 90 days) to process a claim. If an extension is necessary, you will be notified of the special circumstances requiring an extension and the date by which the Plan expects to make a decision on your claim. The extension notice will be provided prior to the end of the initial 90-day period.

Special Rule for Disability Benefits

When you submit a claim for disability benefits, the claims administrator will notify you of its decision regarding the claim within 45 days of receipt. If your claim cannot be decided during this timeframe due to matters beyond the control of the Plan, the claims administrator will notify you that up to an additional 30 days are required to review your claim. If the claims administrator determines that, due to continued matters beyond the control of the Plan, a decision cannot be made within that extension period, the claims administrator will notify you that up to another 30 days are required to decide your claim. Any notice of an extension will be made prior to the expiration of the current review period, and will include information about the circumstances requiring the extension and the date by which the claims administrator expects to make a decision. If your claim is deficient, the notice of extension will describe the standards on which your entitlement to benefits is based, any unresolved issues that prevent a decision on the claim, and any additional information needed to resolve those issues. You will then have at least 45 days from receipt of the notice to submit additional information.

Explanation of Denied Claims

If your claim for benefits (other than health care benefits) is denied, the written explanation of the denial will:

- give specific reasons for the denial, citing applicable plan provisions;
- describe any additional material or information necessary to perfect the claim;
- explain why such materials or information is necessary;
- describe the steps you can take to ask for a review of the decision;
- explain your right to bring a civil action against the Plan under ERISA Section 502(a) following the denial of an appeal;
- In the case of a denial of disability benefits:
 - disclose any internal rule, guideline, protocol, or similar criterion relied on in denying the claim (or a statement that such information will be provided free of charge upon request); and
 - if the denial is based on medical necessity, experimental treatment or similar exclusion, explain the scientific or clinical judgment relied on for the determination (or a statement that such explanation will be provided free of charge upon request).

You have additional rights regarding the filing of claims. Refer to "**How to Appeal if Your Claim Is Denied**" in this section.

How to Appeal if Your Claim Is Denied

If you submit a claim for benefits and your claim is denied, you or any person you choose to represent you may file a written appeal with the claims administrator. You will be informed of when and where to direct an appeal when your claim is denied. Except for appeals involving urgent care (see the "**Urgent Care Claims**" section), all appeals must be in writing. You may submit comments, documents, and other information in support of your appeal. The review of the appeal will take into account any information you submit, even if it was not submitted or considered as part of the initial determination. To prepare your appeal, you can obtain, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim.

Your Deadline to Appeal a Claim Denial

You have 180 days from receipt of the notice of denial to appeal a claim denial under a health care plan or for disability benefits. You have 60 days from receipt of the notice of denial to appeal a claim denial for any benefit claim other than health care and disability.

Your written appeal of a health care claim denial should include the following:

- the patient's name and identification number as shown on the Plan ID card;
- the date of the medical service;
- the provider's name;
- the reason you believe the claim should be paid; and
- any documentation or other written information to support your request for claim payment.

Your written appeal of any other type of claim denial should include any related documents, issues, comments and reasons why you think your claim should not be denied.

Appeals for Health Care Claims

The Company has delegated full discretion, authority, and fiduciary responsibility for claims and appeals decisions to the claims administrators for the health care plans (as listed above), *excluding issues of Plan eligibility and Health Care FSA or Limited Use Health Care FSA claims, which will be decided by an Appeals Committee or other fiduciary appointed by the Plan Administrator.* The Company has delegated authority to decide appeals for denials of prescription drug benefit claims to MCMC, LLC, an independent contractor of Express Scripts, Inc., the prescription drug claims administrator.

First Level Appeals

The review of the first level appeal will afford no deference to the initial benefit determination. Someone other than an individual involved in the initial benefit determination or a subordinate of such individual will be appointed to decide the first level appeal. All first level appeals (except

those involving urgent care) should be submitted in writing to the claims administrator within 180 days after you receive the notice of determination.

If your claim was denied based on a medical judgment (such as whether a service or supply is experimental or medically necessary), the claims administrator will consult with a health care professional with appropriate training and experience. The health care professional consulted for the first level appeal will not be the professional (if any) consulted during the prior determination or a subordinate of such professional. The claims administrator also will identify, at your request, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denied benefit determination being appealed, even if the advice was not relied upon in making the benefit determination.

The claims administrator or Appeals Committee, as applicable, will provide you written or electronic (via e-mail) notification of the determination, as follows:

- *For first level appeals of pre-service claims*, no later than 15 days after receipt of your request for a first level appeal.
- *For first level appeals of post-service and concurrent claims*, no later than 30 days after receipt of your request for a first level appeal.

NOTE: If you are a participant in the Health Care FSA or Limited Use Health Care FSA, you will only have one level of appeal before a final decision on your claim is reached. You will be provided written or electronic notification (via e-mail) of the determination, as follows:

- *For appeals of pre-service claims*, no later than 30 days after receipt of your request for a first level appeal.
- *For appeals of post-service and concurrent claims*, no later than 60 days after receipt of your request for a first level appeal.

Second Level Appeals

If you are not satisfied with the determination of the claims administrator on your first level appeal, you can submit a second level appeal. All second level appeals (except those involving urgent care) should be submitted in writing to the claims administrator within 180 days after you receive the notice of determination on your first level appeal. (For information on urgent care appeals, see "**Urgent Care Appeals**" below.)

Like first level appeals, the review of a second level appeal will afford no deference to prior determinations and will be conducted by someone other than individuals involved in the prior determinations or subordinates of such individuals. Also, if the first level appeal was denied based on a medical judgment, the claims administrator will consult a health professional other than the professional consulted for the first level appeal.

The claims administrator will provide you written or electronic (via e-mail) notification of the determination, as follows:

- *For appeals of pre-service claims*, no later than 15 days after receipt of your request for a second level appeal.
- *For appeals of post-service and concurrent claims*, no later than 30 days after receipt of your request for a second level appeal.

NOTE: There is no second level appeal for participants in the Health Care FSA or Limited Use Health Care FSA, as described above in this section.

Urgent Care Appeals

An appeal involves urgent care if:

- A delay could significantly increase the risk to your health or impair your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your condition, a delay could cause severe pain that could not be adequately managed without the care or treatment.

If your appeal involves urgent care, the appeal does not need to be submitted in writing. You or your physician should call the claims administrator for urgent care appeals, at the number indicated on your Plan ID card, as soon as possible.

The claims administrator will provide you written or electronic (via e-mail) notification of the determination as soon as possible, but no later than 72 hours after receipt of the appeal.

Denials of Health Care Appeals

Denial notifications for all health care appeals will:

- state why the claim has been denied, citing applicable plan provisions;
- state that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim;
- explain your right to bring a civil action against the Plan under ERISA Section 502(a) within 90 days of receipt of the denial;
- specify any internal rules, guidelines, protocols or similar criteria relied upon in making the determination (or, it will include a statement that such rules, guidelines, protocols or criteria were relied upon in denying the appeal and are available upon request, free of charge); and
- if the denial on appeal is based on a medical necessity, experimental treatment or similar exclusion, explain the scientific or clinical judgment for the denied benefit determination (or a statement that such explanation will be provided free of charge upon request).

You may not file any lawsuits to recover a Plan benefit until you have exercised all of your rights under these benefit claims procedures and received a final denial of your appeal.

Health Care Claim and Appeal Timeline

Summary of Time Limits for Claims and Appeals			
Action	Post-Service Care Claim	Pre-Service Care Claim (Non Urgent)	Urgent Care Claim
Initial decision on complete claim	30 days*	15 days*	72 hours
How long you have to submit your appeal of a denied claim	180 days	180 days	180 days
Final decision on appeal			
• First level appeal	30 days	15 days	72 hours total
• Second level appeal**	30 days	15 days	for both levels

* *Extension may be necessary if proper notice has been given and the delay is beyond the Plan's control.*

** *Second level appeals are not available in the Health Care FSA or Limited Use Health Care FSA. The claims administrators or Appeals Committee, as applicable, will provide final appeal decisions within 60 days for post-service claims, within 30 days for pre-service care claims, and within 72 hours for urgent care claims.*

Appeals for Disability Benefits

The company has delegated full discretion and authority for claims and appeals decisions to the claims administrator for Short-term Disability benefits and the insurance company for Long-term Disability benefits, *excluding issues of Plan eligibility, which will be decided by an Appeals Committee appointed by the Plan Administrator.*

The claims administrator or Appeals Committee, as applicable, generally will notify you of its decision regarding your appeal within 45 days of receipt. If your appeal cannot be decided during this timeframe due to special circumstances, you will be notified prior to the end of the initial 45-day period that an extension of up to 45 days is required. The notice of extension will describe the special circumstances requiring the extension and the date by which the decision on review will be made.

The appeal review will be made without giving any deference to the initial claim denial. If the initial claim denial was based in whole or in part on medical judgment, the claims administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was not consulted in connection with the initial claim denial or a subordinate of any such individual. The claims administrator also will identify, at your request, medical or vocational experts whose advice was obtained in connection with the claim denial, even if the advice was not relied upon in making the benefit determination.

If your appeal is denied, the written notice will:

- state why the claim has been denied, citing applicable plan provisions;
- state that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim;
- explain your right to bring a civil action against the Plan under ERISA Section 502(a) within 90 days of receipt of the denial;
- specify any internal rules, guidelines, protocols or similar criteria relied upon in making the determination (or, it will include a statement that such rules, guidelines, protocols or criteria were relied upon in denying the appeal and are available upon request, free of charge); and
- if the denial on appeal is based on a medical necessity, experimental treatment or similar exclusion, explain the scientific or clinical judgment for the denied benefit determination (or a statement that such explanation will be provided free of charge upon request).

You may not file any lawsuits to recover a Plan benefit until you have exercised all of your rights under these benefit claims procedures and received a final denial of your appeal.

Appeals for 401(k) and Severance Benefits

The Plan Administrator has appointed an Appeals Committee to review denied claims for 401(k) and severance benefits.

The Appeals Committee meets at least quarterly. Normally, the Appeals Committee will make its final decision on behalf of the Plan Administrator no later than the date of its next meeting following the date the Plan Administrator receives your request for a review. However, if your request is filed within 30 days before the next meeting, a final decision normally will be made no later than the date of the second meeting following the date the Plan Administrator receives your request for a review. If an extension is necessary (up to the third meeting following the date the Plan Administrator receives your request for a review), the Appeals Committee will notify you in writing of the reasons for the delay and the date you may expect the final decision.

The Appeals Committee decision shall be a final and binding written decision as to whether the claim has been approved or denied upon review, and will:

- state why the claim has been denied, citing applicable plan provisions;
- state that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim; and
- explain your right to bring a civil action against the Plan under ERISA Section 502(a) within 90 days of receipt of the denial.

You may not file any lawsuits to recover a Plan benefit until you have exercised all of your rights under these benefit claims procedures and received a final denial of your appeal.

Appeals for Other Insured Benefits

The Plan Administrator has appointed an Appeals Committee to review denied claims for *eligibility* for insured vision, term life, accidental death and dismemberment, or business travel accident benefits. The Appeals Committee meets at least quarterly. Normally, the Appeals Committee will make its final decision on behalf of the Plan Administrator no later than the date of its next meeting following the date the Plan Administrator receives your request for a review. However, if your request is filed within 30 days before the next meeting, a final decision normally will be made no later than the date of the second meeting following the date the Plan Administrator receives your request for a review. If an extension is necessary (up to the third meeting following the date the Plan Administrator receives your request for a review), the Appeals Committee will notify you in writing of the reasons for the delay and the date you may expect the final decision.

The insurance company will review denied claims for insured vision, term life, accidental death and dismemberment, or business travel accident benefits not based on plan eligibility. The insurance company will make its final decision no later than 60 days following the date the insurance company receives your request for a review. If necessary, the insurance company may need an extension to review denied claims. If an extension is necessary (up to another 60 days), the insurance company will notify you in writing of the reasons for the delay and when you may expect the final decision.

Decisions of the Appeals Committee and the insurance company will be final and binding written decisions as to whether the claim has been accepted or denied upon review, and will:

- state why the claim has been denied, citing applicable plan provisions;
- state that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim; and
- explain your right to bring a civil action against the Plan under ERISA Section 502(a) within 90 days of receipt of the denial.

You may not file any lawsuits to recover a Plan benefit until you have exercised all of your rights under these benefit claims procedures and received a final denial of your appeal.

HIPAA Privacy and Security Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information ("PHI"), includes virtually all individually identifiable health information held by the health plan – whether received in writing, in an electronic medium, or as an oral communication. The HIPAA privacy rules impact the Medical Plan, Dental Plan, Vision Plan, Health Care FSA and the Limited Use Health Care FSA (collectively referred to as "the Plan", unless specified otherwise). These plans may share information with each other to carry out treatment, payment, or health care operations. Health

information developed for other purposes (i.e. your disability benefits) is not covered by these privacy rules. PHI is information that:

- is created or received by the Plan; and
- relates to present, past or future;
 - physical or mental health or condition,
 - provision of or payment for health care, and
 - permits individual identification.

PHI does not include employment records.

The Company has access to PHI only as permitted by the Plan or as otherwise required or permitted by HIPAA. Certain Company employees have access to PHI for specific purposes. Job titles for such employees are included with the Company's Policy of Privacy of Health Information available from PeopleLink. Employees who do not comply with the privacy rules will be subject to disciplinary action by the Company.

The Plan may provide PHI to designated Company employees without your authorization for the following administrative purposes:

- enrollment/disenrollment information;
- summary health information;
- plan amendments;
- claims processing and payments;
- appeals decisions, if applicable;
- assisting with claims issues;
- auditing Plan operations and payments; and
- monitoring performance of health networks, insurers, HMOs and third party administrators.

The Company may also use or disclose your PHI without your authorization for the following activities:

- disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws;
- disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Plan reasonably believes may have caused serious

physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody;

- disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects;
- disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk);
- disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information);
- disclosures to law enforcement officials required by law or pursuant to legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises;
- disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties;
- disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death; and
- disclosures for research purposes, health oversight activities, specialized government functions, and the Department of Health and Human Services investigations.

Also in certain cases, your health information can be disclosed **without** your written authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to such persons (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Company and the Plan will not use or disclose your PHI in any other way without your written authorization.

The Company will not use or disclose PHI for employment-related actions or for the administration of any other employee benefit plan.

Business associates of the Plan, such as third party administrators, HMOs, and other service providers, are subject to the same restrictions and conditions that apply to the Company.

You may give the Plan written authorization to use your medical information or to disclose it to anyone for any purpose. If you give the Plan authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give the Plan a written authorization, it cannot use or disclose your medical information for any reason except those described in this section.

At your written request to PeopleLink or third party administrator, the Plan will:

- make your own PHI available to you;
- amend your PHI for accuracy, if the Plan agrees that amendment is appropriate;
- provide you an accounting of any disclosures of your PHI that were not made for plan administration purposes;
- send communications about your PHI to you at alternative locations or by alternative means, if normal means would endanger you; and
- place special restrictions on the use and disclosure of your PHI, if the Plan concludes that your request is reasonable.

The Company has procedures in place to ensure that PHI received from the Plan is securely safeguarded, including special safeguards for electronic PHI. The Company will return or destroy all PHI received from the Plan once such PHI is no longer needed. The Company will make its internal practices, books and records available to the Secretary of Health and Human Services for audit of the Plan's compliance with HIPAA privacy requirements. The Company will report to the Plan any use or disclosure of PHI of which it is aware that is inconsistent with these rules, and any incident that may affect the security of electronic PHI.

The Plan will provide a HIPAA Privacy Notice to all new participants and within 60 days after any material changes in the Notice.

The Company has certified to the Plan that the Plan has included the requirements set forth in this section and that the Company has agreed to these requirements.

Statement of Your Rights Under Federal Law (ERISA)

As a participant in these Plans, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. (The Plan Administrator is the person who manages the Plan.)
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report. (Not applicable to certain plans.)
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (generally age 65) and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge. (Not applicable to certain plans.)

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse, domestic partner, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Administrative Information About the Plans

Plan Sponsor

Schneider Electric Holdings, Inc.
1415 South Roselle Road
Palatine, Illinois 60067
(847) 397-2600

The Plans are maintained by Schneider Electric Holdings, Inc. (the "Company") and any of its subsidiary or affiliate members of the Schneider Electric controlled group that adopt the Plans with the Company's consent (referred to together as the "employers"). If a subsidiary or affiliate leaves the Schneider Electric controlled group, they will no longer be an employer under the Plans. In the event of the dissolution, merger or consolidation of an employer, the Plans will terminate as to that employer unless the Plans are continued by a successor to the employer with the consent of the Company.

Any action required to be taken by Schneider Electric Holdings, Inc. or an employer under the Plans shall be by resolution of its Board of Directors, by resolution of a duly authorized committee of its Board of Directors, or by a person or persons authorized by resolution of its Board of Directors or such committee.

For purposes of this Schneider Electric Benefit Program for U.S. Employees, where appropriate the term "Company" also includes the other employers who have adopted the Plans.

Employer Identification Number

36-4141566

Plan Administrator

For the Schneider Electric Benefit Program, the Schneider Electric Benefits Committee (the "Committee") shall be the Plan Administrator for purposes of Section 3(16) of the Employee Retirement Income Security Act of 1974 (ERISA) and shall have responsibility for administering the Plans and complying with any ERISA reporting and disclosure laws applicable to the Plans for any plan year. The Company delegates to insurance companies or third party administrators issuing insurance contracts or acting as a claims administrator under some of the Plans the discretionary authority to make claims determinations (including factual determinations and interpretations of Plan terms) and, for some types of benefits, appeals determinations, and to apply prevailing industry standards and practices in doing so. The Plan Administrator has delegated to an Appeals Committee the discretionary authority to make appeals determinations in regard to issues of Plan eligibility and for the Health Care FSA or Limited Use Health Care FSA claims.

The Committee as Plan Administrator shall have the sole authority in the exercise of its discretion to interpret, apply and administer the terms of the Plans and to determine eligibility for participation, eligibility for benefits and the amount of any benefits under the Plans, and its determination of any such matters shall be final and binding, except to the extent such authority has been delegated to an insurance company or Appeals Committee. Benefits under the Plans will be paid only if the Plan Administrator, or an insurance company or Appeals Committee to

whom authority has been delegated, decides in its discretion that the applicant is entitled to them.

The Plan Administrator will administer the Plans on a reasonable and nondiscriminatory basis and will apply uniform rules to all covered persons similarly situated. A misstatement or other mistake of fact will be corrected when it becomes known to the parties, and the Plan Administrator will make such adjustment on account thereof as it considers equitable and practicable. Neither the Plan Administrator, the claims administrators nor any employer will be liable in any manner for any determination of fact made in good faith.

The Plan Administrator's name, address and telephone number is as follows:

Schneider Electric Benefits Committee
1415 South Roselle Road
Palatine, Illinois 60067
(847) 397-2600

Agent for Service of Legal Process

Secretary
Schneider Electric Holdings, Inc.
1415 South Roselle Road
Palatine, Illinois 60067
(847) 397-2600

For all the Plans under the Schneider Electric Benefit Program for U.S. Employees, the Agent for Service of Legal Process is the Secretary of Schneider Electric Holdings, Inc. Legal process also can be served on the Plan Administrator or a Plan Trustee.

Funding

The Schneider Electric 401(k) Plan is funded through a trust agreement with the trustee listed in the "Claims Administrator, Insurer or Trustee" column on the following pages.

The Schneider Electric Benefit Program plans are funded directly through the Company's general assets and employee contributions, or through insurance contracts. Benefits are considered part of a cafeteria plan entitled the Schneider Electric Cafeteria Plan.

Facility of Payment

If you or a covered dependent are under legal disability, or in the opinion of the Plan Administrator are in any way incapacitated so as to be unable to manage your financial affairs, the Plan Administrator may direct the claims administrator to make payments or distributions to:

- The covered person's legal representative, or
- Until a claim is made by a conservator or other person legally charged with the care of the person, to a relative or friend of such covered person for such person's benefit.

Or, the Plan Administrator may direct payments or distributions for the benefit of the covered person in any manner that is consistent with the provisions of the Plans. Any payments so made will be a full and complete discharge of any liability for such payment under the Plan.

Benefits Not Transferable

Except as otherwise permitted by the Plan Administrator to assign benefits to providers, or as may be required by a qualified domestic relations order, a qualified medical child support order, or applicable tax withholding laws, or pursuant to an agreement between you and the Company, your benefits under the Plans are not in any way subject to your or your dependents' debts and may not be voluntarily sold, transferred, alienated or assigned.

You or your beneficiary can obtain, without charge, a copy of the procedures governing determinations of qualified domestic relations orders and qualified medical child support orders from the Plan Administrator.

Recovery of Benefits

If you or a covered dependent receive a benefit payment under a Plan which is in excess of the benefit payment which should have been made, the Plan Administrator has the right to recover the amount of the excess. The Plan Administrator may, however, at its option, direct the claims administrator or trustee to deduct the amount of the excess from any subsequent benefits payable under the Plan to or for the benefit of you or the covered dependent.

Information to be Furnished

You must furnish the Company, the Plan Administrator, the insurance companies and the claims administrators with all information they consider necessary or desirable to administer the Plans. If you engage in fraud or make an intentional misrepresentation or omission of a material fact in an enrollment form or a claim for benefits under the Schneider Electric Benefit Program for U.S. Employees or the Business Travel Accident Plan, it may be used to rescind coverage or to deny claims for benefits under the Plans.

Physical Exam

The Plan Administrator, at its own expense, has the right and opportunity to have the person whose injury or sickness is the basis of a claim, examined by a Physician designated by it, when and as often as it may reasonably require while a claim is pending under the Plans.

Governing Law

The Plans shall be governed by the laws of Illinois, to the extent not superseded by federal law. If any part of any Plan is determined to be invalid or illegal for any reason, the remaining provisions of the Plan shall be applied as if the illegal or invalid provision had never been a part of the Plan.

Litigation

To the extent permitted by law, if a legal action begun by or on behalf of any person against the Plan Administrator, the Company or any other employer under a Plan (or any employee, officer or member of the Board of Directors of the Company or any other employer) with respect to benefits payable under the Plan results adversely to that person, or if a legal action arises because of conflicting claims to a covered person's benefits, the cost incurred by the party defending the action will be charged to the amount, if any, that was involved in the action or was payable to the covered person concerned.

Plan Documents

The following Plans are participating plans in the Schneider Electric Benefit Program for U.S. Employees. The complete provisions of the Plans are found in the official Plan document, which rules in the case of any differences between it and this information.

- **Medical Plan** – The **Medical – PPO**, **Medical – EPO**, and **Medical - HDHP** and the **General Information** and **Administrative Facts** sections, as they relate to the **Medical - PPO**, **Medical – EPO**, and **Medical – HDHP** are the official plan documents for the **Medical Plan**.
- **Dental Plan** – The **Dental Plan** and the **General Information** and **Administrative Facts** sections, as they relate to **Dental Plan**, are the official plan document for the **Dental Plan**.
- **Life and AD&D Plan** – The **Life and AD&D** and the **General Information** and the **Administrative Facts** sections, as they relate to the **Life and AD&D Plan**, are the official plan document for the **Life and AD&D Plan**, subject to the provisions of any insurance contract providing term life, accidental death and dismemberment and dependent life insurance. The provisions of any such insurance contract are incorporated by reference as part of the **Life and AD&D Plan**, and will control in the event of any conflict.
- **Disability Plan** – The **Disability** and the **General Information** and the **Administrative Facts** sections, as they relate to the **Disability Plan**, are the official plan document for the **Disability Plan**, subject to the provisions of any insurance contract providing long-term disability benefits. The provisions of any such insurance contract are incorporated by reference as part of the **Disability Plan**, and will control in the event of any conflict.
- The **Health Care Flexible Spending Account**, **Limited Use Health Care Flexible Spending Account** and **Dependent Care Flexible Spending Account** and the **General Information** and **Administrative Facts** sections, are set forth in the Cafeteria Plan document.

The plan documents for the remaining benefits that are not part of the Schneider Electric Benefit Program for U.S. Employees are as follows:

- **Business Travel Accident Plan** – The **Business Travel Accident** section and the **Administrative Facts** section, as it relates to the **Business Travel Accident Plan**, are the official plan document for the **Business Travel Accident Plan**, subject to the provisions of any insurance contract providing business travel insurance. The provisions of any such insurance contract are incorporated by reference as a part of the **Business Travel**

Accident Plan, and will control in the event of any conflict with this summary plan description.

- The **Severance Plan** and **Schneider Electric 401(k) Plan** are set forth in separate plan documents. The official plan documents will rule in the case of any differences between them and this summary plan description.

Information About Your Insurance Certificates

To help you understand your benefits, this material provides a general description of the different options. Any benefits that are provided through an insurance company or contract, and the provisions that apply to them, are described fully in the insurance certificates that apply to each insured benefit. The benefits that have insurance certificates are Life and AD&D, Disability and Business Travel Accident. If you would like a copy of any insurance certificates, please contact PeopleLink.

Additional Plan Information

Plan Name	Type of Plan	Plan Number	Plan Year	Effective Date	Funding Method	Source of Contributions	Claims Administrator, Insurer or Trustee
Schneider Electric Medical Plan	welfare	501	January 1 - December 31	Effective January 1, 2011	self-insured/ general assets	Company and employee contributions	PPO, EPO and High Deductible Health Plan (HDHP) Options Blue Cross and Blue Shield of Illinois P.O. Box 805107 Chicago, IL 60680-4112 Claims Administrator and Express Scripts, Inc. P.O. Box 390873 Bloomington, MN 55439-0873 Claims Administrator
Schneider Electric Dental Plan	welfare	501	January 1 - December 31	Effective January 1, 2010	self-insured/ general assets	Company and employee contributions	Delta Dental Plan of Illinois PO Box 5402 Lisle, IL 60532-5402 Claims Administrator
Schneider Electric Vision Plan	welfare	501	January 1 – December 31	Effective January 1, 2011	self-insured/ general assets	Employee contributions	Spectera P.O. Box 30978 Salt Lake City, UT 84130 Insurer
Schneider Electric Life and AD&D Plan	welfare	501	January 1 – December 31	Effective January 1, 2011	insurance policy	Company and employee contributions	Unum Group Life Benefits P.O. Box 9061 Portland, ME 04104-5046 Insurer

Plan Name	Type of Plan	Plan Number	Plan Year	Effective Date	Funding Method	Source of Contributions	Claims Administrator, Insurer or Trustee
Schneider Electric Disability Plan	welfare	501	January 1 – December 31	Effective January 1, 2011	STD: self-insured/ general assets LTD: insurance policy	Company and employee contributions	Prudential P.O. Box 13480 Philadelphia, PA 19176 Claims Administrator/Insurer
Schneider Electric Health Care Flexible Spending Account (FSA)	health care reimbursement	501	January 1 – December 31	Effective January 1, 2011	self-insured/ general assets	Company and employee contributions	PayFlex P.O. Box 3039 Omaha, NE 68103-3039 Claims Administrator
Schneider Electric Dependent Care Flexible Spending Account (FSA)	dependent care reimbursement	501	January 1 - December 31	Effective January 1, 2011	self-insured/ general assets	Employee contributions	PayFlex Systems USA, Inc. P.O. Box 3039 Omaha, NE 68103-3039 Claims Administrator
Schneider Electric Limited Use Health Care Flexible Spending Account (FSA)	health care reimbursement	501	January 1 – December 31	Effective January 1, 2011	self-insured/ general assets	Employee contributions	PayFlex Systems USA, Inc. P.O. Box 3039 Omaha, NE 68103-3039 Claims Administrator
Health Savings Account			January 1 – December 31	Effective January 1, 2011		Company and employee contributions	PayFlex Systems USA, Inc. 10802 Farnam Drive, Ste 100 Omaha, NE 68154 Trustee

Plan Name	Type of Plan	Plan Number	Plan Year	Effective Date	Funding Method	Source of Contributions	Claims Administrator, Insurer or Trustee
Schneider Electric Business Travel Accident Plan	travel accident	518	January 1 - December 31	Effective January 1, 2010	insurance policy	Company contributions	CHUBB Group of Insurance Companies 233 South Wacker Drive Suite 4700 Chicago, IL 60606-6303 Insurer
Schneider Electric 401(k) Plan	defined contribution plan	301	January 1 – December 31	Effective January 1, 2010	held in trust	Company and employee contributions	The Vanguard Fiduciary Trust Company Vanguard Financial Center Valley Forge, PA 19482 Trustee
Schneider Electric Employees' Severance Plan	severance pay benefit plan	511	January 1 – December 31	January 1, 2011	self-insured/ general assets	Company contributions	Schneider Electric Holdings, Inc. 1415 South Roselle Road Palatine, IL 60067 Claims Administrator
Schneider Electric Severance Allowance Plan for Coordinated Bargaining Employees (Oxford, OH)	severance pay benefit plan	504	January 1 - December 31	September 24, 1987	self-insured/ general assets	Company contributions	Schneider Electric USA, Inc. 1415 South Roselle Road Palatine, IL 60067 Claims Administrator

Note: The plans listed as Plan No. 501 are sub-plans of the Schneider Electric Benefit Program for U.S. Employees

The sections of this document, called Summary Plan Descriptions, summarize the Schneider Electric Benefit Program for U.S. Employees in easy-to-understand language. The complete provisions of the Plans are found in the official Plan documents, which rule in the case of any differences between them and this information.

Refer to each benefit section for the effective date of the Schneider Electric Benefit Program described in this summary.

Participation in the Schneider Electric Benefit Program for U.S. Employees in no way guarantees employment with the Company.

While the Company expects to continue the Schneider Electric Benefit Program for U.S. Employees indefinitely, it reserves the right to terminate, suspend, withdraw, amend or modify all or any part of the Plans, to change the cost of coverage, or to provide for different funding mechanisms at any time without notice. Any such change or termination of the Plans will be based solely on any decision of the Plan Sponsor and/or the Plan Administrator and may apply to any or all groups of employees – including active and disabled employees, and current or future retirees and their dependents – as determined under the Plan.

No supervisor, manager or other representative of the Company has any authority to enter into any oral or written agreement contrary to the foregoing or contrary to the terms of any summary plan description or applicable plan document.

EXHIBIT D

Your Health Care Benefit Program



Accenture LLP Enhanced PPO Plan

Administered by:



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.™

A message from

Accenture LLP

This booklet describes the Health Care Plan which we provide to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your health care claims, we have engaged Blue Cross and Blue Shield of Illinois as Claim Administrator.

Please read the information in this benefit booklet carefully so you will have a full understanding of your health care benefits. If you want more information or have any questions about your health care benefits, please contact the Employee Benefits Department.

Effective January 1, 2014 Optum Rx is the prescription drug provider for Blue-Cross and BlueShield PPO plan members. For prescription drug costs and coverage, visit www.myuhc.com, call 1-877-468-0998 or review the Accenture Prescription Drug Plan Summary Plan Description.

Sincerely,

Accenture LLP

NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those Providers.

Please refer to the provision entitled “Claim Administrator’s Separate Financial Arrangements with Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Please note that the Claim Administrator has contracts, either directly or indirectly, with many prescription drug providers that provide the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those providers.

Please refer to the provision entitled “Claim Administrator’s Separate Financial Arrangements with Prescription Drug Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Blue Cross and Blue Shield of Illinois provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

**WARNING, LIMITED BENEFITS WILL BE PAID WHEN
NON-PARTICIPATING PROVIDERS ARE USED**

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy’s fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the plan. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED UNDER THIS COVERAGE AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

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BENEFIT HIGHLIGHTS

(Employees with a base salary under \$100,000)

Your health care benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire benefit booklet.

THE UTILIZATION REVIEW PROGRAM

A special program designed to assist you in determining the course of treatment that will maximize your benefits under this benefit booklet

Lifetime Maximum
for all Benefits

Unlimited

Individual Deductible

- Participating Provider \$300 per benefit period
- Non-Participating and
Non-Administrator Provider \$2,500 per benefit period

Family Deductible

- Participating Provider \$600 per benefit period
- Non-Participating and
Non-Administrator Provider \$5,000 per benefit period

Individual Out-of-Pocket
Expense Limit

(does not apply to all services)

- Participating Provider \$2,600 per benefit period
- Non-Participating Provider \$5,000 per benefit period

Family Out-of-Pocket
Expense Limit

- Participating Provider \$5,200 per benefit period
- Non-Participating Provider \$10,000 per benefit period

Chiropractic and Osteopathic
Manipulation Benefit Maximum

20 visits per benefit period
combined in and out of network

HOSPITAL BENEFITS

Payment level for Covered
Services from a
Participating Provider:

- Inpatient Covered Services 85% of the Eligible Charge
after you have satisfied your
program deductible
- Outpatient Covered
Services 85% of the Eligible Charge
after you have satisfied your
program deductible

- Wellness Care 100% of the Eligible Charge, no deductible

Payment level for Covered Services from a

Non-Participating Provider:

- Inpatient Covered Services 65% of the Eligible Charge after you have satisfied your program deductible
- Outpatient Covered Services 65% of the Eligible Charge after you have satisfied your program deductible
- Wellness Care Not covered

Payment level for Covered Services from a

Non-Administrator Provider

65% of the Eligible Charge

Hospital Emergency Care

- Payment level for Emergency Accident Care from either a Participating, Non-Participating or Non-Administrator Provider 85% of the Eligible Charge after you have satisfied your program deductible
- Payment level for Emergency Medical Care from either a Participating, Non-Participating or Non-Administrator Provider 85% of the Eligible Charge after you have satisfied your program deductible

PHYSICIAN BENEFITS

Payment level for Surgical/Medical Covered Services

- **Participating Provider** 85% of the Maximum Allowance after you have satisfied your program deductible
- **Non-Participating Provider** 65% of the Maximum Allowance after you have satisfied your program deductible

Payment level for Emergency Accident Care

85% of the Maximum Allowance after you have satisfied your program deductible

Payment level for Emergency Medical Care 85% of the Maximum Allowance after you have satisfied your program deductible

Payment level for Wellness Care

— **Participating Provider** 100% of the Maximum Allowance, no deductible

— **Non-Participating Provider** Not covered

OTHER COVERED SERVICES

Payment level 85% of the Eligible Charge or Maximum Allowance after you have satisfied your program deductible

TO IDENTIFY NON-ADMINISTRATOR AND ADMINISTRATOR HOSPITALS OR FACILITIES, YOU SHOULD CONTACT THE CLAIM ADMINISTRATOR BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR IDENTIFICATION CARD.

BENEFIT HIGHLIGHTS**(Employees with a base salary \$100,000 and over)**

Your health care benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire benefit booklet.

**THE UTILIZATION
REVIEW PROGRAM**

A special program designed to assist you in determining the course of treatment that will maximize your benefits under this benefit booklet

Lifetime Maximum
for all Benefits

Unlimited

Individual Deductible

- Participating Provider \$500 per benefit period
- Non-Participating and
Non-Administrator Provider \$2,500 per benefit period

Family Deductible

- Participating Provider \$1,000 per benefit period
- Non-Participating and
Non-Administrator Provider \$5,000 per benefit period

Individual Out-of-Pocket
Expense Limit

(does not apply to all services)

- Participating Provider \$3,100 per benefit period
- Non-Participating Provider \$5,000 per benefit period

Family Out-of-Pocket
Expense Limit

- Participating Provider \$6,200 per benefit period
- Non-Participating Provider \$10,000 per benefit period

Chiropractic and Osteopathic
Manipulation Benefit Maximum

20 visits per benefit period
combined in and out of network

HOSPITAL BENEFITS

Payment level for Covered
Services from a

Participating Provider:

- Inpatient Covered Services 85% of the Eligible Charge
after you have satisfied your
program deductible
- Outpatient Covered
Services 85% of the Eligible Charge
after you have satisfied your
program deductible

of 1230

- Wellness Care 100% of the Eligible Charge,
no deductible

Payment level for Covered
Services from a

Non-Participating Provider:

- Inpatient Covered Services 65% of the Eligible Charge
after you have satisfied your
program deductible
- Outpatient Covered
Services 65% of the Eligible Charge
after you have satisfied your
program deductible
- Wellness Care Not covered

Payment level for Covered
Services from a

Non-Administrator Provider

65% of the Eligible Charge

Hospital Emergency Care

- Payment level for
Emergency Accident
Care from either a
Participating,
Non-Participating or
Non-Administrator Provider 85% of the Eligible Charge
after you have satisfied your
program deductible
- Payment level for
Emergency Medical
Care from either
a Participating,
Non-Participating or
Non-Administrator Provider 85% of the Eligible Charge
after you have satisfied your
program deductible

PHYSICIAN BENEFITS

Payment level for Surgical/
Medical Covered Services

- **Participating Provider** 85% of the Maximum Allowance
after you have satisfied your
program deductible
- **Non-Participating Provider** 65% of the Maximum Allowance
after you have satisfied your
program deductible

Payment level for Emergency
Accident Care

85% of the Maximum Allowance
after you have satisfied your
program deductible

Payment level for Emergency Medical Care 85% of the Maximum Allowance after you have satisfied your program deductible

Payment level for Wellness Care

- **Participating Provider** 100% of the Maximum Allowance, no deductible
- **Non-Participating Provider** Not covered

OTHER COVERED SERVICES

Payment level 85% of the Eligible Charge or Maximum Allowance after you have satisfied your program deductible

TO IDENTIFY NON-ADMINISTRATOR AND ADMINISTRATOR HOSPITALS OR FACILITIES, YOU SHOULD CONTACT THE CLAIM ADMINISTRATOR BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR IDENTIFICATION CARD.

DEFINITIONS SECTION

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

ADMINISTRATOR PROGRAM.....means programs for which a Hospital has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time services are rendered to you. These programs are limited to a Partial Hospitalization Treatment Program or Coordinated Home Care Program.

ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

ADVANCED PRACTICE NURSE.....means Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist.

AMBULANCE TRANSPORTATION.....means local transportation in a specially equipped certified vehicle from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.

AMBULATORY SURGICAL FACILITY.....means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

An “Administrator Ambulatory Surgical Facility” means an Ambulatory Surgical Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Ambulatory Surgical Facility” means an Ambulatory Surgical Facility which does not meet the definition of an Administrator Ambulatory Surgical Facility.

ANESTHESIA SERVICES.....means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them respectively.

AVERAGE DISCOUNT PERCENTAGE (“ADP”).....means a percentage discount determined by the Claim Administrator that will be applied to a Provider’s Eligible Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by the Claim Administrator to be relevant to the particular Claim. The ADP reflects the Claim Administrator’s reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect related costs. (See provisions of this benefit booklet regarding “Claim Administrator’s Separate Financial Arrangements with Providers.”) In determining the ADP applicable to a particular Claim, the Claim Administrator will take into account differences among Hospitals and other facilities, the Claim Administrator’s contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when your benefits under the Health Care Plan are secondary to Medicare and/or coverage under any other group program.

BEHAVIORAL HEALTH PRACTITIONER.....means a Physician or Professional Provider who is duly licensed to render services for Mental Illness, Serious Mental Illness or Substance Use Disorders.

CERTIFICATE OF CREDITABLE COVERAGE.....means a certificate disclosing information relating to your Creditable Coverage under a health care benefit program.

CERTIFIED CLINICAL NURSE SPECIALIST.....means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- (ii) is a graduate of an advanced practice nursing program.

A “Participating Certified Clinical Nurse Specialist” means a Certified Clinical Nurse Specialist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Clinical Nurse Specialist” means a Certified Clinical Nurse Specialist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE-MIDWIFE.....means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- (ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

A “Participating Certified Nurse-Midwife” means a Certified Nurse-Midwife who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Nurse-Midwife” means a Certified Nurse-Midwife who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE PRACTITIONER.....means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- (ii) is a graduate of an advanced practice nursing program.

A “Participating Certified Nurse Practitioner” means a Certified Nurse Practitioner who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Nurse Practitioner” means a Certified Nurse Practitioner who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED REGISTERED NURSE ANESTHETIST or CRNA.....means a nurse anesthetist who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by

the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

A “Participating Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CHEMOTHERAPY.....means the treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

CHIROPRACTOR.....means a duly licensed chiropractor.

CLAIM.....means notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

CLAIM ADMINISTRATOR.....means Blue Cross and Blue Shield of Illinois.

CLAIM CHARGE.....means the amount which appears on a Claim as the Provider’s charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding “The Claim Administrator’s Separate Financial Arrangements with Providers.”)

CLAIM PAYMENT.....means the benefit payment calculated by the Claim Administrator, after submission of a Claim, in accordance with the benefits described in this benefit booklet. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding “The Claim Administrator’s Separate Financial Arrangements with Providers.”)

CLINICAL LABORATORY.....means a clinical laboratory which complies with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, the Medicare and Medicaid programs and any applicable state and local statutes and regulations.

A “Participating Clinical Laboratory” means a Clinical Laboratory which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Laboratory” means a Clinical Laboratory which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan provide services to you at the time services are rendered.

CLINICAL PROFESSIONAL COUNSELOR.....means a duly licensed clinical professional counselor.

A “Participating Clinical Professional Counselor” means a Clinical Professional Counselor who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Professional Counselor” means a Clinical Professional Counselor who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL SOCIAL WORKER.....means a duly licensed clinical social worker.

A “Participating Clinical Social Worker” means a Clinical Social Worker who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Social Worker” means a Clinical Social Worker who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this program.

COINSURANCE.....means a percentage of an eligible expense that you are required to pay towards a Covered Service.

COMPLICATIONS OF PREGNANCY.....means all physical effects suffered as a result of pregnancy which would not be considered the effect of normal pregnancy.

COORDINATED HOME CARE PROGRAM.....means an organized skilled patient care program in which care is provided in the home. Care may be pro-

vided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

An "Administrator Coordinated Home Care Program" means a Coordinated Home Care Program which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time service is rendered to you.

A "Non-Administrator Coordinated Home Care Program" means a Coordinated Home Care Program which does not have an agreement with the Claim Administrator or a Blue Cross Plan but has been certified as a home health agency in accordance with the guidelines established by Medicare.

COPAYMENT.....means a specified dollar amount that you are required to pay towards a Covered Service.

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE.....means the date on which your coverage under the Health Care Plan begins.

COVERED SERVICE.....means a service and supply specified in this benefit booklet for which benefits will be provided.

CREDITABLE COVERAGE.....means coverage you had under any of the following:

- (i) a group health plan.
- (ii) Health insurance coverage for medical care under any hospital or medical service policy plan, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.
- (iii) Medicare (Parts A or B of Title XVIII of the Social Security Act).
- (iv) Medicaid (Title XIX of the Social Security Act).
- (v) Medical care for members and certain former members of the uniformed services and their dependents.
- (vi) A medical care program of the Indian Health Service or of a tribal organization.

- (vii) A State health benefits risk pool.
- (viii) A health plan offered under the Federal Employees Health Benefits Program.
- (ix) A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country.
- (x) A health plan under Section 5(e) of the Peace Corps Act.
- (xi) State Children's Health Insurance Program (Title XXI of the Social Security Act).

CUSTODIAL CARE SERVICE.....means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you.

DENTIST.....means a duly licensed dentist.

DIAGNOSTIC SERVICE.....means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

DIALYSIS FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

An "Administrator Dialysis Facility" means a Dialysis Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Dialysis Facility" means a Dialysis Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with the guidelines established by Medicare.

DOMESTIC PARTNER.....means a person with whom you have entered into a Domestic Partnership.

DOMESTIC PARTNERSHIP.....means long-term committed relationship of indefinite duration with a person of the same or opposite sex which meets the following criteria:

- (i) you and your Domestic Partner have lived together for at least 6 months,
- (ii) neither you nor your Domestic Partner is married to anyone else or has another domestic partner,
- (iii) your Domestic Partner is at least 18 years of age and mentally competent to consent to contract
- (iv) your Domestic Partner resides with you and intends to do so indefinitely,
- (v) you and your Domestic Partner have an exclusive mutual commitment similar to marriage, and
- (vi) you and your Domestic Partner are not related by blood closer than would bar marriage in the state of your legal residence (i.e., the blood relationship is not one which would forbid marriage in the state of your residence, if you and the Domestic Partner were of the opposite sex).

You and your Domestic Partner must be jointly responsible for each other's common welfare and must share financial obligations. Joint responsibility may be demonstrated by the existence of at least 3 of the following: a signed Affidavit of Domestic Partnership, a joint mortgage or lease, designation of you or your Domestic Partner as a beneficiary in the other partner's life insurance and retirement contract, designation of you or your Domestic Partner as the primary beneficiary in your or your Domestic Partner's will, durable property and health care powers of attorney, or joint ownership of a motor vehicle, checking account or credit account.

DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider.

A "Participating Durable Medical Equipment Provider" means a Durable Medical Equipment Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Durable Medical Equipment Provider" means a Durable Medical Equipment Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ELIGIBLE CHARGE.....means (a) in the case of a Provider, other than a Professional Provider, which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care

to you at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider, other than a Professional Provider, which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, will be the lesser of:

- (i) the Provider's billed charges, or;
- (ii) the Claim Administrator non-contracting Eligible Charge. Except as otherwise provided in this section, the non-contracting Eligible Charge is developed from base Medicare reimbursements and represents approximately 300% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Eligible Charge for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating or Non-Administrator Provider's standard billed charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Eligible Charge for Non-Participating or Non-Administrator Providers will be 50% of the Non-Participating or Non-Administrator Provider's standard billed charge for such Covered Service.

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Provider Claims for processing Claims submitted by Non-Participating or Non-Administrator Providers which may also alter the Eligible Charge for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

ELIGIBLE PERSON.....means an employee of the Employer who meets the eligibility requirements for this health and/or dental coverage, as described in the ELIGIBILITY SECTION of this benefit booklet.

EMERGENCY ACCIDENT CARE.....means the initial Outpatient treatment of accidental injuries including related Diagnostic Services. The initial Outpa-

tient treatment does not include surgical procedures, including but not limited to, stitching, gluing and casting.

EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (ii) serious impairment to bodily functions; or
- (iii) serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION.....means an admission for the treatment of Mental Illness or Substance Use Disorders as a result of the sudden and unexpected onset of a Mental Illness or Substance Use Disorder condition such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

EMPLOYER.....means the company with which you are employed.

ENROLLMENT DATE.....means the first day of coverage under your Employer's health plan or, if your Employer has a waiting period prior to the effective date of your coverage, the first day of the waiting period (typically, the date employment begins).

FAMILY COVERAGE.....means coverage for you and your eligible dependents under the Health Care Plan.

HOME INFUSION THERAPY PROVIDER.....means a duly licensed home infusion therapy provider.

A "Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who does not have a written agreement with the

Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

HOSPICE CARE PROGRAM PROVIDER.....means an organization duly licensed to provide Hospice Care Program Service.

HOSPICE CARE PROGRAM SERVICE.....means a centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility or special hospice care unit.

HOSPITAL.....means a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

An "Administrator Hospital" means a Hospital which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Hospital" means a Hospital that does not meet the definition of an Administrator Hospital.

A "Participating Hospital" means an Administrator Hospital that has an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide Hospital services to participants in the Participating Provider Option program.

A "Non-Participating Hospital" means an Administrator Hospital that does not meet the definition of a Participating Hospital.

INDIVIDUAL COVERAGE.....means coverage under the Health Care Plan for yourself but not your spouse and/or dependents.

INPATIENT.....means that you are a registered bed patient and are treated as such in a health care facility.

INTENSIVE OUTPATIENT PROGRAM.....means a freestanding or Hospital-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat Mental Illness or Substance Use Disorders or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorders. Dual diagnosis programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions which make it unlikely that you will benefit from programs that focus solely on Mental Illness conditions. Dual diagnosis programs are delivered by Behavioral Health Practitioners who are cross-trained.

Intensive Outpatient Program services may be available with less intensity if you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder conditions. If you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder conditions, services may include psychotherapy, pharmacotherapy, and other interventions aimed at supporting recovery such as the development of recovery plans and advance directives, strategies for identifying and managing early warning signs of relapse, development of self-management skills, and the provision of peer support services.

Intensive Outpatient Programs may be used as an initial point of entry into care, as a step up from routine Outpatient services, or as a step down from acute Inpatient, residential care or a Partial Hospitalization Treatment Program.

INVESTIGATIONAL or INVESTIGATIONAL SERVICES AND SUPPLIES.....means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

LONG TERM CARE SERVICES.....means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury or condition.

MAINTENANCE CARE.....means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY.....means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

MARRIAGE AND FAMILY THERAPIST ("LMFT").....means a duly licensed marriage and family therapist.

A "Participating Marriage and Family Therapist" means a Marriage and Family Therapist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Marriage and Family Therapist" means a Marriage and Family Therapist who does not have a written agreement with the

Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

MATERNITY SERVICE.....means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

MAXIMUM ALLOWANCE.....means (a) the amount which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Professional Providers will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. (b) For Non-Participating Professional Providers, the Maximum Allowance will be the lesser of:

- (i) the Provider's billed charges, or;
- (ii) the Claim Administrator non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 300% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Maximum Allowance for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating Professional Provider's standard billed charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Maximum Allowance for Non-Participating Professional Providers will be 50% of the Non-Participating Professional Provider's standard billed charge for such Covered Service.

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Professional Provider Claims for processing Claims submitted by Non-Participating Professional Providers which may also alter the Maximum Allowance for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

MEDICAL CARE.....means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

MEDICALLY NECESSARY.....SEE EXCLUSIONS SECTION OF THIS BENEFIT BOOKLET.

MEDICARE.....means the program established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.).

MEDICARE APPROVED or MEDICARE PARTICIPATING.....means a Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

MEDICARE SECONDARY PAYER or MSP.....means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

MENTAL HEALTH UNIT.....means a unit established to assist in the administration of Mental Illness and Substance Use Disorder Rehabilitation Treatment benefits including Preauthorization, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Use Disorders.

MENTAL ILLNESS.....means those illnesses classified as disorders in the current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

“Serious Mental Illness”.....means the following mental disorders as classified in the current *Diagnostic and Statistical Manual* published by the American Psychiatric Association:

- (i) Schizophrenia;
- (ii) Paranoid and other psychotic disorders;
- (iii) Bipolar disorders (hypomanic, manic, depressive and mixed);
- (iv) Major depressive disorders (single episode or recurrent);
- (v) Schizoaffective disorders (bipolar or depressive);
- (vi) Pervasive developmental disorders;

- (vii) Obsessive-compulsive disorders;
- (viii) Depression in childhood and adolescence;
- (ix) Panic disorder;
- (x) Post-traumatic stress disorders (acute, chronic, or with delayed onset); and
- (xi) Anorexia nervosa and bulimia nervosa.

NAPRAPATH.....means a duly licensed naprapath.

NAPRAPATHIC SERVICES.....means the performance of naprapathic practice by a Naprapath which may legally be rendered by them.

NON-ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

OCCUPATIONAL THERAPIST.....means a duly licensed occupational therapist.

OCCUPATIONAL THERAPY.....means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

OPTOMETRIST.....means a duly licensed optometrist.

A “Participating Optometrist” means an Optometrist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Optometrist” means an Optometrist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ORTHOTIC PROVIDER.....means a duly licensed orthotic provider.

A “Participating Orthotic Provider” means an Orthotic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/

or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Orthotic Provider” means an Orthotic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PARTIAL HOSPITALIZATION TREATMENT PROGRAM.....means a Claim Administrator approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Rehabilitation Treatment in which patients spend days or nights.

PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

PARTICIPATING PRESCRIPTION DRUG PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER OPTION.....means a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

PHARMACY.....means any licensed establishment in which the profession of pharmacy is practiced.

PHYSICAL THERAPIST.....means a duly licensed physical therapist.

PHYSICAL THERAPY.....means the treatment of a disease, injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider.

PODIATRIST.....means a duly licensed podiatrist.

PREAUTHORIZATION, PREAUTHORIZE or EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION REVIEW.....means a submission of a request to the Mental Health Unit for a determination of Medically Necessary care under this benefit booklet.

PRIVATE DUTY NURSING SERVICE.....means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PROSTHETIC PROVIDER.....means a duly licensed prosthetic provider.

A “Participating Prosthetic Provider” means a Prosthetic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Prosthetic Provider” means a Prosthetic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you.

An “Administrator Provider” means a Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Provider” means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.

A “Participating Provider” means an Administrator Hospital or Professional Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or an Administrator facility which has been designated by the Claim Administrator as a Participating Provider.

A “Non-Participating Provider” means an Administrator Hospital or Professional Provider which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or a facility which has not been designated by the Claim Administrator as a Participating Provider.

A “Professional Provider” means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist or any Provider designated by the Claim Administrator or another Blue Cross and/or Blue Shield Plan.

A “Participating Prescription Drug Provider” means a Pharmacy that has a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer its prescription drug program to provide services to you at the time you receive the services.

PSYCHOLOGIST.....means a Registered Clinical Psychologist.

Registered Clinical Psychologist means a Clinical Psychologist who is registered with the Illinois Department of Financial and Professional Regulation pursuant to the Illinois “Psychologists Registration Act” or, in a state where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program; or

is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

REGISTERED SURGICAL ASSISTANT.....means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant.

A “Participating Registered Surgical Assistant” means a Registered Surgical Assistant who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Registered Surgical Assistant” means a Registered Surgical Assistant who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

RENAL DIALYSIS TREATMENT.....means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

RESIDENTIAL TREATMENT CENTER.....means a facility setting offering therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision and structure and is licensed by the appropriate state and local authority to provide such service. It does not include halfway houses, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with Mental Illness and/or Substance Use Disorders.

RESPIRE CARE SERVICE.....means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services to you.

RETAIL HEALTH CLINIC.....means a health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by Certified Nurse Practitioners.

A “Participating Retail Health Clinic” means a Retail Health Clinic which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Retail Health Clinic” means a Retail Health Clinic which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

SKILLED NURSING FACILITY.....means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

An “Administrator Skilled Nursing Facility” means a Skilled Nursing Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Skilled Nursing Facility” means a Skilled Nursing Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with guidelines established by Medicare.

An “Uncertified Skilled Nursing Facility” means a Skilled Nursing Facility which does not meet the definition of an Administrator Skilled Nursing Fa-

cility and has not been certified in accordance with the guidelines established by Medicare.

SKILLED NURSING SERVICE.....means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

SPEECH THERAPIST.....means a duly licensed speech therapist.

SPEECH THERAPY.....means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

SUBSTANCE USE DISORDER.....means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Behavioral Health Practitioner, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

SUBSTANCE USE DISORDER TREATMENT FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment of Substance Use Disorders and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

An "Administrator Substance Use Disorder Treatment Facility" means a Substance Use Disorder Treatment Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Substance Use Disorder Treatment Facility” means a Substance Use Disorder Treatment Facility that does not meet the definition of an Administrator Substance Use Disorder Treatment Facility.

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claim Administrator.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

TOTALLY DISABLED.....means with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

ELIGIBILITY SECTION

The Employer provides the Claims Administrator with information regarding the eligibility of its' employees. For an explanation of the eligibility provisions, please see the Summary Plan Description for the Participating Medical Plan under the Accenture Group Health Plan found in the Plan Information page on the Knowledge Library tab at the Live Well at Accenture website, <http://resources.hewitt.com/accenture>.

UTILIZATION REVIEW PROGRAM

The Claim Administrator has established the Utilization Review Program to assist you in determining the course of treatment that will maximize your benefits under this Health Care Plan. The Utilization Review Program requires a review of the following Covered Services **before** such services are rendered:

- Inpatient Hospital services
- Skilled Nursing Facility services
- Services received in a Coordinated Home Care Program
- Private Duty Nursing Services
- Infertility Treatment

You are responsible for satisfying Preadmission/Admission Review requirements. This means that you must ensure that you, your family member, or Provider of services must comply with the guidelines below. Failure to obtain Preadmission/Admission Review for services will require additional steps and/or benefit reductions as described in the provision entitled FAILURE TO NOTIFY. The toll-free telephone number for Preadmission/Admission Review is on your ID card. Please read the provisions below very carefully.

The Utilization Review Program does not apply to the treatment of Mental Illness or Substance Abuse Rehabilitation Treatment. The treatment of Mental Illness or Substance Abuse Rehabilitation Treatment is subject to the provisions specified in the CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT section of this benefit booklet.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever a nonemergency or nonmaternity Inpatient Hospital admission is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the Hospital admission.

If the proposed Hospital admission or health care services are determined to be not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised verbally of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. These letters may not be received prior to your scheduled date of admission.

- **Emergency Admission Review**

Emergency admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

In the event of an emergency admission, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days or as soon as reasonably possible after the admission has occurred.

- **Pregnancy/Maternity Admission Review**

Pregnancy/Maternity admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Health Care Plan.

In the event of a maternity admission, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days after the admission has occurred.

Even though you are not required to call the Claim Administrator prior to your maternity admission, if you call the medical pre-notification number as soon as you find out you are pregnant, the Claim Administrator will provide you information on support programs to assist you during pregnancy.

- **Skilled Nursing Facility Preadmission Review**

Skilled Nursing Facility preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever an admission to a Skilled Nursing Facility is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

- **Coordinated Home Care Program Preadmission Review**

Coordinated Home Care Program preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever an admission to a Coordinated Home Care Program is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

- **Private Duty Nursing Service Review**

Private Duty Nursing Service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever Private Duty Nursing Service is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to receiving services.

CASE MANAGEMENT

Case management is a collaborative process that assists you with the coordination of complex care services. A Claim Administrator case manager is available to you as an advocate for cost-effective interventions.

Case managers are also available to you to provide assistance when you need alternative benefits. Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost-effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Health Care Plan.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Upon completion of the preadmission or emergency review, the Claim Administrator will send a letter to your Physician and/or the Hospital confirming that you or your representative called the Claim Administrator and that an approved length of service or length of stay was assigned.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. In the event that the extension is determined not to be Medically Necessary, the authorization will not be extended. Additional notification will be provided to your Physician and/or the Hospital regarding the denial of payment for the extension.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the Claim Administrator. The Claim Administrator will provide notification of a decision to not authorize payment for Inpatient care or other health care services or supplies to you,

your Physician, and/or the Hospital or other Provider. The notification will specify the dates, services and/or supplies that are not considered Covered Services. For further details regarding Medically Necessary care and other exclusions from coverage, see the EXCLUSIONS - WHAT IS NOT COVERED section in this benefit booklet.

The Claim Administrator does not determine your course of treatment or whether you receive particular health care services. Decisions regarding the course of treatment and receipt of particular health care services are a matter entirely between you and your Physician. The Claim Administrator's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is a Covered Service under the Health Care Plan.

In the event that the Claim Administrator determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service charge incurred.

Remember that the Claim Administrator's Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not determined to be Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as medically necessary, the Claim Administrator will not pay for the hospitalization, services or supplies unless the Claim Administrator determines it to be Medically Necessary and a Covered Service under the Health Care Plan.

NOTE: Keep in mind that a Medically Necessary determination does not guarantee that benefits are available. For example, it might be determined that a service is Medically Necessary, however, the Health Care Plan may limit or exclude that service. In that case, the Medically Necessary determination does not override the benefit provision in the benefit booklet.

UTILIZATION REVIEW PROCEDURE

The following information is required when you contact the Claim Administrator:

1. The name of the attending and/or admitting Physician;
2. The name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;
3. The scheduled admission and/or service date; and
4. A preliminary diagnosis or reason for the admission and/or service.

Upon receipt of the required information, the Claim Administrator:

1. will review the information provided and seek additional information as necessary.
2. will issue a determination that the services are either Medically Necessary or are not Medically Necessary.
3. will provide notification of the determination.

APPEAL PROCEDURE

If you or your Physician disagree with the determination of the Claim Administrator prior to or while receiving services, you may appeal that decision. You should call the Claim Administrator's customer service number on your identification card. Your Physician should use the contact information in the notification letter.

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Medical Director
Health Care Service Corporation
P. O. Box A3957
Chicago, Illinois 60601

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Claim Administrator will not interfere with your relationship with any Provider. However, the Claim Administrator has established the Utilization Review Program for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits provided under this benefit booklet.

Should you fail to notify the Claim Administrator as required in the Preadmission Review provision of this section, you will then be responsible for the first \$500 of the charges for eligible Covered Services for gamete intrafallopian tube transfer (GIFT) and/or zygote intrafallopian tube transfer (ZIFT) in addition to any deductibles, Copayments and/or Coinsurance applicable to this benefit booklet.

MEDICARE ELIGIBLE MEMBERS

The preadmission review provisions of this Utilization Review Program do not apply to you if you are Medicare eligible and have secondary coverage provided under the Health Care Plan.

CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT

The Claim Administrator's Mental Health Unit has been established to assist in the administration of Mental Illness and Substance Use Disorder Rehabilitation Treatment benefits, including Preauthorization review, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for your Inpatient Hospital admissions and/or Outpatient services for the treatment of Mental Illness and Substance Use Disorders. The Mental Health Unit has staff which includes Physicians, Psychologists, Clinical Social Workers and registered nurses.

Failure to contact the Mental Health Unit or to comply with the determinations of the Mental Health Unit may result in a reduction of benefits. The Mental Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Behavioral Health Practitioner or Provider of services must comply with the guidelines below. Failure to Preauthorize services will require additional steps and/or benefit reductions as described in the provision entitled FAILURE TO PREAUTHORIZE OR NOTIFY.

PREAUTHORIZATION REVIEW

- **Inpatient Hospital Preauthorization Review**

Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

In order to receive maximum benefits under this Health Care Plan, you must Preauthorize your nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Use Disorders by calling the Mental Health Unit. Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the Inpatient Hospital admission.

- **Emergency Mental Illness or Substance Use Disorder Admission Review**

Emergency Mental Illness or Substance Use Disorder Admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

In order to receive maximum benefits under this Health Care Plan, you or someone who calls on your behalf must notify the Mental Health Unit no later than two business days or as soon as reasonably possible after the admission for the treatment of Mental Illness or Substance Use Disorders

has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits. Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

- **Partial Hospitalization Treatment Program Review**

Partial Hospitalization Treatment Program review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

In order to receive maximum benefits under this Health Care Plan, you must notify the Mental Health Unit no later than 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorders has occurred. Participating and Non-Participating Providers may call for you, when required, but it is your responsibility to ensure these requirements are satisfied. This call must be made at least 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorders has occurred. The Mental Health Unit will obtain information regarding the service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

If an Inpatient Emergency Mental Illness or Substance Use Disorder Admission occurs after a service(s), in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Mental Health Unit for an Emergency Mental Illness or Substance Use Disorder Admission Review.

- **Length of Stay/Service Review**

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Upon completion of the Preauthorization or Emergency Mental Illness or Substance Use Disorder Review, the Mental Health Unit will send you a letter confirming that you or your representative called the Mental Health Unit. A letter assigning a length of service or length of stay will be sent to your Behavioral Health Practitioner and/or the Hospital.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by the Mental Health Unit. In the event that the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to a Mental Health Unit Physician for review.

OUTPATIENT SERVICE PREAUTHORIZATION REVIEW

- **Outpatient Service Preauthorization Review**

Outpatient service Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

In order to receive maximum benefits under this Health Care Plan for Outpatient services for the treatment of Mental Illness or Substance Use Disorders, you must Preauthorize the following Outpatient service(s) by calling the Mental Health Unit:

- Psychological testing
- Neuropsychological testing
- Electroconvulsive therapy
- Intensive Outpatient Programs

Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the scheduling of the planned Outpatient services(s). The Mental Health Unit will obtain information regarding the Outpatient service(s). The Mental Health Unit will obtain information regarding the Outpatient service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient Hospital admission, Outpatient service, or other health care services or supplies are not Medically Necessary, as such term is defined in this benefit booklet, will be determined by the Mental Health Unit. If the Mental Health Unit Physician concurs that the Inpatient Hospital admission, Outpatient service, or other health care service or supply does not meet the criteria for Medically Necessary care, some days, services or the entire hospitalization will be denied. Your Behavioral Health Practitioner and in the case of an Inpatient Hospital admissions, the Hospital will be advised by telephone of this determinations, with a follow-up notification letter sent to you, your Behavioral Health Practitioner and the Hospital, and will specify the dates, services or supplies that are not considered Medically Necessary. The Mental Health Unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission or service. For further details regarding Medically Necessary care and other exclusions described in this benefit booklet, see the provision entitled, "EXCLUSIONS - WHAT IS NOT COVERED."

The Mental Health Unit does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is

a matter entirely between you and your Behavioral Health Practitioner. The Mental Health Unit's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization, Outpatient service or other health care service is Medically Necessary under the Health Care Plan.

In the event that the Mental Health Unit determines that all or any portion of an Inpatient Hospital admission, Outpatient service, or other health care service or supply is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service or supply charge incurred.

Remember that your Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Behavioral Health Practitioner or another health care Provider may prescribe, order, recommend or approve an Inpatient Hospital admission, Outpatient service or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Behavioral Health Practitioner prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the Mental Health Unit Physician decides they were not Medically Necessary.

MENTAL HEALTH UNIT PROCEDURE

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission, Outpatient service, and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review you should be prepared to provide the following information:

1. the name of the attending and/or admitting Behavioral Health Practitioner;
2. the name of the Hospital or facility where the admission and/or service has been scheduled, when applicable;
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission, Outpatient service, and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review, the Mental Health Unit:

1. will review the medical information provided and follow-up with the Behavioral Health Practitioner;
2. upon request, will advise you of Participating Providers in the area who may be able to provide the admission and/or services that are the subject of the Preauthorization Review;

3. may determine that the admission and/or services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

Expedited Appeal

If you or your Behavioral Health Practitioner disagrees with the determinations of the Mental Health Unit prior to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Mental Health Unit and requesting an expedited appeal. The Mental Health Unit Physician will review your case and determine whether the service was Medically Necessary. You and/or your Behavioral Health Practitioner will be notified of the Mental Health Unit Physician's determination within twenty-four (24) hours or no later than the last authorized day. If you or your Behavioral Health Practitioner still disagree with the Mental Health Unit Physician, you may request an appeal in writing as outlined below.

Written Appeal

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after Claim processing has taken place or upon receipt of the notification letter from the Mental Health Unit, you may appeal that decision by having your Behavioral Health Practitioner call the contact person indicated in the notification letter or by submitting a written request to:

Blue Cross and Blue Shield of Illinois
Appeals Coordinator
Blue Cross and Blue Shield BH Unit
P. O. Box 660240
Dallas, Texas 75266-0240
Fax Number: 1-877-361-7656

You must exercise the right to this appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to the Claim Administrator as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may review any relevant documents held by the Claim Administrator, if you request an appointment in writing.

Within 30 days of receiving your request for review, the Claim Administrator will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO PREAUTHORIZE OR NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Mental Health Unit will not interfere with your relationship with any Behavioral Health Practitioner. However, the Mental Health Unit has been established for the specific purpose of assisting you in maximizing your benefits as described in this benefit booklet.

MEDICARE ELIGIBLE MEMBERS

The provisions of the CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT section do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Health Care Plan.

THE PARTICIPATING PROVIDER OPTION

Your Employer has chosen the Claim Administrator's "Participating Provider Option" for the administration of your Hospital and Physician benefits. The Participating Provider Option is a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

As a participant in the Participating Provider Option a directory of Participating Providers is available to you. You can visit the Blue Cross and Blue Shield of Illinois Web site at www.bcbsil.com for a list of Participating Providers. While there may be changes in the directory from time to time, selection of Participating Providers by the Claim Administrator will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided to your Employer annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Participating Provider.

Before reading the description of your benefits, you should understand the terms "Benefit Period" and "Deductible" as defined below.

YOUR BENEFIT PERIOD

Your benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first December 31st following that date.

YOUR DEDUCTIBLE

(Employees with a base salary under \$100,000)

Each benefit period you must satisfy a \$300 deductible for Covered Services rendered by Participating Provider(s) and a separate \$2,500 deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Administrator Provider(s). In other words, after you have claims for Covered Services for more than the deductible amount in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.

(Employees with a base salary of \$100,000 or over)

Each benefit period you must satisfy a \$500 deductible for Covered Services rendered by Participating Provider(s) and a separate \$2,500 deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Administrator Provider(s). In other words, after you have claims for Covered Services for more than the deductible amount in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.

FAMILY DEDUCTIBLE

All charges applied to the individual deductible amount will be applied towards the family deductible amount. Once a person meets their individual deductible, no more deductible is required for that individual. When the family deductible is reached, no further deductibles will have to be satisfied for the remainder of that benefit period. No participant will contribute more than the individual deductible amount to the family deductible amount.

(Employees with a base salary under \$100,000)

If you have Family Coverage and your family has reached the program deductible amount of \$600 for Covered Services rendered by Participating Provider(s) and a separate \$5,000 program deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Administrator Provider(s), it will not be necessary for anyone else in your family to meet the program deductible in that benefit period. That is, for the remainder of that benefit period only, no other family member(s) is required to meet the program deductible before receiving benefits. A family member may not apply more than the individual program deductible amount toward the family program deductible.

(Employees with a base salary of \$100,000 or over)

If you have Family Coverage and your family has reached the program deductible amount of \$1,000 for Covered Services rendered by Participating Provider(s) and a separate \$5,000 program deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Administrator Provider(s), it will not be necessary for anyone else in your family to meet the program deductible in that benefit period. That is, for the remainder of that benefit period only, no other family member(s) is required to meet the program deductible before receiving benefits. A family member may not apply more than the individual program deductible amount toward the family program deductible.

In any case, should two or more members of your family ever receive Covered Services as a result of injuries received in the same accident, only one program deductible will be applied against those Covered Services.

HOSPITAL BENEFIT SECTION

Expenses for Hospital care are usually the biggest of all health care costs. Your Hospital benefits will help ease the financial burden of these expensive services. This section of your benefit booklet tells you what Hospital services are covered and how much will be paid for each of these services.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

INPATIENT CARE

The following are Covered Services when you receive them as an Inpatient in a Hospital.

Inpatient Covered Services

1. Bed, board and general nursing care when you are in:
 - a semi-private room
 - a private room
 - an intensive care unit
2. Ancillary services (such as operating rooms, drugs, surgical dressings and lab work)

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery.

These tests are considered part of your Inpatient Hospital surgical stay.

Partial Hospitalization Treatment

Benefits are available for this program only if it is an Administrator Program. No benefits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by the Claim Administrator.

Coordinated Home Care

Benefits will be provided for services under a Coordinated Home Care Program.

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

Participating Provider

When you receive Inpatient Covered Services from a Participating Provider or in an Administrator Program of a Participating Provider, benefits will be provided at 85% of the Eligible Charge after you have met your program deductible, unless otherwise specified in this benefit booklet. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds. Benefits for a private room rate will be payable only when such private room is deemed Medically Necessary.

Non-Participating Provider

When you receive Inpatient Covered Services from a Non-Participating Provider or in an Administrator Program of a Non-Participating Provider, benefits will be provided at 65% of the Eligible Charge, after you have met your program deductible. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds. Benefits for a private room rate will be payable only when such private room is deemed Medically Necessary.

Non-Administrator Provider

When you receive Inpatient Covered Services from a Non-Administrator Provider, benefits will be provided at the same benefit payment level which would have been paid had such services been received from a Non-Participating Provider.

OUTPATIENT HOSPITAL CARE

The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services

1. Surgery and any related Diagnostic Service received on the same day as the Surgery
2. Radiation Therapy Treatments
3. Chemotherapy
4. Electroconvulsive Therapy
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care
7. Emergency Accident Care—treatment must occur within 72 hours of the accident or as soon as reasonably possible.
8. Emergency Medical Care

9. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

Participating Provider

Benefits will be provided at 85% of the Eligible Charge after you have met your program deductible when you receive Outpatient Hospital Covered Services from a Participating Provider.

Benefits for a routine colonoscopy, performed by a Participating Provider as a surgical procedure, will be provided at 100% of the Eligible Charge and your program deductible will not apply. Such benefits will be provided only once in a three (3) year period. An additional colonoscopy for diagnostic purposes, or an additional routine colonoscopy within the three year period, will be provided at 85% of the Eligible Charge after you have met your program deductible.

Non-Participating Provider

When you receive Outpatient Hospital Covered Services from a Non-Participating Provider, benefits will be provided at 65% of the Eligible Charge after you have met your program deductible.

Benefits for a routine colonoscopy, performed by a Non-Participating Provider as a surgical procedure, will be provided at 100% of the Eligible Charge and your program deductible will not apply. Such benefits will be provided only once in a three (3) year period. An additional colonoscopy for diagnostic purposes, or an additional routine colonoscopy within the three (3) year period, will be provided at 65% of the Eligible Charge after you have met your program deductible.

Non-Administrator Provider

When you receive Outpatient Hospital Covered Services from a Non-Administrator Provider, benefits will be provided at the same payment level which would have been paid had such services been received from a Non-Participating Provider.

Emergency Care

Benefits for Emergency Accident Care will be provided at 85% of the Eligible Charge when you receive Covered Services from either a Participating, Non-Participating or Non-Administrator Provider. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the Emergency Accident Care payment level. Such services will be provided at the benefit payment level for Surgery described in this benefit booklet.

Benefits for Emergency Accident Care will be subject to the Participating Provider program deductible.

Benefits for Emergency Medical Care will be provided at 85% of the Eligible Charge when you receive Covered Services from either a Participating, Non-Participating or Non-Administrator Provider.

Benefits for Emergency Medical Care will be subject to the Participating Provider program deductible.

However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge whether or not you have met your program deductible.

Notwithstanding anything in this benefit booklet to the contrary, the method used to determine the Maximum Allowance for Emergency care services will be equal to the greatest of the following three possible amounts:

1. the amount negotiated with Participating Providers for emergency care benefits furnished; or
2. the amount for the emergency care service calculated using the same method the Participating Providers generally uses to determine payments for Non-Participating Provider services but substituting the Participating cost sharing provisions for the Non-Participating Provider cost-sharing provisions; or
3. the amount that would be paid under Medicare for the emergency care service.

Each of these three amounts is calculated excluding any Non-Participating Provider Copayment or Coinsurance imposed with respect to the covered person.

WHEN SERVICES ARE NOT AVAILABLE FROM A PARTICIPATING PROVIDER (HOSPITAL)

If you must receive Hospital Covered Services which the Claim Administrator has reasonably determined are unavailable from a Participating Provider, benefits for the Covered Services you receive from a Non-Participating Provider will be provided at the payment level described for a Participating Provider.

PHYSICIAN BENEFIT SECTION

This section of your benefit booklet tells you what services are covered and how much will be paid when you receive care from a Physician or other specified Professional Provider.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available under this Benefit Section, services must be Medically Necessary and you must receive such services on or after your Coverage Date.

Remember, whenever the term “you” or “your” is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Surgery

Benefits are available for Surgery performed by a Physician, Dentist or Podiatrist. However, for services performed by a Dentist or Podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under this Health Care Plan had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

1. surgical removal of complete bony impacted teeth;
2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

1. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon’s office or Ambulatory Surgical Facility.

In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.
3. Sterilization Procedures (even if they are elective).

Medical Care

Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital, a Skilled Nursing Facility, or Substance Use Disorder Treatment Facility or
2. you are a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program or
3. you visit your Physician's office or your Physician comes to your home.

Consultations

Your coverage includes benefits for consultations. The consultation must be requested by your Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who also renders Surgery or Maternity Service during the same admission.

Diabetes Self-Management Training and Education

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professionals with expertise in diabetes management. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

Nutritional Counseling—Benefits will be provided for nutritional counseling for children ages 3 up to age 18. Benefits are limited to 4 visits per benefit period.

Diagnostic Service—Benefits will be provided for those services related to covered Surgery or Medical Care.

Emergency Accident Care—Treatment must occur within 72 hours of the accident or as soon as reasonably possible.

Emergency Medical Care

Electroconvulsive Therapy

Allergy Injections and Allergy Testing

Chemotherapy

Occupational Therapy

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The treatment plan must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

Your benefits can be denied or shortened if you are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Additional visits may be allowed based on Medical Necessity. Please note that the Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or re-occurring.

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The treatment plan must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

Your benefits can be denied or shortened if you are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Additional visits may be allowed based on Medical Necessity. Please note that the Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or re-occurring.

Chiropractic and Osteopathic Manipulation—Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Your benefits for chiropractic and osteopathic manipulation will be limited to a maximum of 20 visits per benefit period.

Radiation Therapy Treatments

Speech Therapy

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The treatment plan must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.

Your benefits can be denied or shortened if you are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Additional visits may be allowed based on Medical Necessity. Please note that the Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or re-occurring.

Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician.

Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Durable Medical Equipment—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates and any other internal and permanent devices. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

Amino Acid-Based Elemental Formulas—Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is medically necessary. If you purchase the formula at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet.

Orthotic Devices

Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary. However, benefits will not be provided for foot orthotics defined as any in-shoe device designed to support the structural components of the foot during weight-bearing activities.

Outpatient Contraceptive Services

Benefits will be provided for prescription contraceptive devices, injections, implants and Outpatient contraceptive services covered through the medical plan. Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

Prosthetic Appliances

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

1. they are required to replace all or part of an organ or tissue of the human body, or
2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required).

Pulmonary Rehabilitation Therapy—Benefits will be provided for outpatient cardiac/pulmonary rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services.

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

The benefits provided by the Claim Administrator and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Professional Provider.

Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist, benefits will be provided at 85% of the Maximum Allowance after you have met your program deductible, unless otherwise specified in this benefit booklet. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this benefit booklet and may bill you for the difference between the Claim Administrator's benefit payment and the Provider's charge to you.

If you are a male, and you receive Covered Services for a vasectomy from a Participating Provider, benefits will be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

Non-Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Non-Participating Provider, benefits will be provided at 65% of the Maximum Allowance after you have met your program deductible.

However, when you receive benefits for nutritional counseling from a Non-Participating Provider benefits will be provided at 85% of the Maximum Allowance after you have met your program deductible.

Emergency Care

Benefits for Emergency Accident Care will be provided at 85% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider after you have met your Participating Provider program deductible. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the Emergency Accident Care payment level. Such services will be provided at the benefit payment level for Surgery described in this benefit booklet.

Benefits for Emergency Medical Care will be provided at 85% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider after you have met your program deductible.

However, Covered Services for Emergency Accident Care and Emergency Medical Care resulting from a criminal sexual assault or abuse will be paid at 100% of the Maximum Allowance whether or not you have met your program deductible.

Notwithstanding anything in this benefit booklet to the contrary, the method used to determine the Maximum Allowance for Emergency care services will be equal to the greatest of the following three possible amounts:

1. the amount negotiated with Participating Providers for emergency care benefits furnished; or
2. the amount for the emergency care service calculated using the same method the Participating Providers generally uses to determine payments for Non-Participating Provider services but substituting the Participating cost sharing provisions for the Non-Participating Provider cost-sharing provisions; or
3. the amount that would be paid under Medicare for the emergency care service.

Each of these three amounts is calculated excluding any Non-Participating Provider Copayment or Coinsurance imposed with respect to the covered person.

Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics

- Speech Therapists

who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists
- other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to

these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider or the Claim Administrator.

OTHER COVERED SERVICES

OTHER COVERED SERVICES

This section of your benefit booklet describes “Other Covered Services” and the benefits that will be provided for them.

- The processing, transporting, storing, handling and administration of blood and blood components.
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.
- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- Oxygen and its administration
- Medical and surgical dressings, supplies, casts and splints
- Naprapathic Service — Benefits will be provided for Naprapathic Services when rendered by a Naprapath. Benefits for Naprapathic Services will be limited to a maximum of \$1,000 per benefit period.
- Wigs—Benefits will be provided for wigs and toupees (also known as cranial prostheses) if the hair loss is a result of an accidental injury or is due to the treatment of a malignancy. Benefits for wigs will be limited to a lifetime maximum of \$1,000.
- Nutritional supplements—Benefits will be provided for nutritional supplements or formula when the attending Physician diagnoses a failure to thrive.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

After you have met your program deductible, benefits will be provided at 85% of the Eligible Charge or 85% of the Maximum Allowance for any of the Covered Services described in this section.

When you receive ambulance transportation in connection with Emergency Accident Care or Emergency Medical Care, benefits for ambulance trans-

portation will be provided at 85% of the Eligible Charge or 85% of the Maximum Allowance, whether or not you have met your program deductible.

When you receive Other Covered Services from a Participating or Non-Participating Provider, benefits for Other Covered Services will be provided at the payment levels previously described in this benefit booklet for Hospital and Physician Covered Services.

Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists

who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists
- other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider or the Claim Administrator.

SPECIAL CONDITIONS AND PAYMENTS

There are some special things that you should know about your benefits should you receive any of the following types of treatments:

HUMAN ORGAN TRANSPLANTS

Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have coverage each will have their benefits paid by their own program.
- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in this benefit booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.
- If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this benefit booklet will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant Surgery.
- the evaluation, preparation and delivery of the donor organ.
- the removal of the organ from the donor.
- the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:

- **Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact the Claim Administrator by telephone before your transplant Surgery has been scheduled. The Claim Administrator will furnish you with the names of Hospitals which have Claim Administrator approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any Hospital that does not have a Claim Administrator approved Human Organ Transplant Program.**

- If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this benefit booklet, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.
- Benefits for transportation and lodging are limited to a combined life-time maximum of \$10,000. The maximum amount that will be provided for lodging is \$50 per person per day.
- In addition to the other exclusions of this benefit booklet, benefits will not be provided for the following:
 - Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
 - Travel time and related expenses required by a Provider.
 - Drugs which do not have approval of the Food and Drug Administration.
 - Storage fees.
 - Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.
 - Meals.

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Claim Administrator approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization.

GENDER IDENTITY DISORDER (GID)

Benefits will be provided for the treatment of Gender Identity Disorder (GID) that conform to the World Professional Association for Transgender Health Association (WPATH) Standards of Care for Gender Identity Disorder. Whether the Plan covers a GID treatment will depend on the nature of the treatment and the stage of the Covered Person's GID. A Covered Person may be required to submit documentation to the Plan Administrator in order for GID treatment to be covered under this Plan. Coverage for a GID treatment

recipient under this Plan is limited to a one time only procedure from male to female or female to male. This procedure is limited to persons age 18 or older.

- Transportation is defined as the means of conveyance or travel from the GID treatment recipient home to and from the Hospital where GID treatment will take place.
- Lodging is defined as a temporary place of residence while the recipient is undergoing the GID treatment.
- Transportation and Lodging benefits is intended to provide coverage for items that are a necessity while away from the GID treatment recipient's home.
- If you are the recipient of GID treatment, benefits will be provided for transportation and lodging for you and a companion (s). For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the GID treatment will be performed.

Benefits for transportation and lodging are limited to a combined lifetime maximum of \$10,000. The maximum that will be provided for lodging is \$50 per person per day.

PREVENTIVE CARE SERVICES

Benefits will be provided for the following Covered Services and will not be subject to any deductible, Coinsurance, Copayment or maximum when such services are received from a Participating Provider:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
- immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
- evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents;
- with respect to women, such additional preventive care and screenings, not described above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The preventive care services described above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the website at www.bcbsil.com or contact customer service at the toll-free number on your identification card.

Examples of covered services included are routine annual physicals, immunizations, well child(ren) care, cancer screenings, mammograms, bone density tests, screenings for prostate cancer and colorectal cancer, an annual flu shot, smoking cessation services and healthy diet counseling and obesity screenings/counseling.

Examples of covered immunizations included are Diphtheria, Haemophilus influenza type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, rubella, Tetanus, Varicella and other immunization that is required by law for a child(ren). Immunizations for travel are covered under this provision. Allergy injections are not considered immunizations under this benefit provision.

Preventive services received from a Non-Participating Provider or other routine Covered Services not provided for under this provision will be subject to the deductible, Coinsurance, Copayments and/or benefit maximum as described under the **WELLNESS CARE** provisions of this benefit booklet.

WELLNESS CARE

Benefits will be provided for Covered Services rendered to you, even though you are not ill. Benefits will be limited to the following services:

- Routine diagnostic medical procedures;
- Routine EKG;
- Routine x-ray;
- Routine ovarian cancer screening;
- Routine colorectal cancer screening x-ray;
- Routine colonoscopy (once every three (3) years).

Routine colonoscopy will be covered once every three (3) years under this provision. Diagnostic colonoscopy, and any additional routine colonoscopy within the three (3) year period, will be covered under the Physician Benefit Section.

Participating Provider

When you receive Covered Services for wellness care from a Participating Provider, benefits for wellness care will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance and will not be subject to the program deductible.

Non-Participating Provider

Benefits will not be provided for wellness care received from a Non-Participating Provider.

SKILLED NURSING FACILITY CARE

The following are Covered Services when you receive them in a Skilled Nursing Facility:

1. Bed, board and general nursing care.

2. Ancillary services (such as drugs and surgical dressings or supplies).

No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.

Benefits for Covered Services rendered in an Administrator Skilled Nursing Facility will be provided at 85% of the Eligible Charge after you have met your program deductible.

Benefits for Covered Services rendered in a Non-Administrator Skilled Nursing Facility will be provided at 65% of the Eligible Charge, once you have met your program deductible. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.

AMBULATORY SURGICAL FACILITY

Benefits for all of the Covered Services previously described in this benefit booklet are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

Benefits for services rendered by an Administrator Ambulatory Surgical Facility will be provided at 85% of the Eligible Charge. Benefits for services rendered by a Non-Administrator Ambulatory Surgical Facility will be provided at 65% of the Eligible Charge.

Benefits for Outpatient Surgery will be provided as stated above after you have met your program deductible.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT

Benefits for all of the Covered Services described in this benefit booklet are available for Substance Use Disorder Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Use Disorder Treatment Facility. Inpatient benefits for these Covered Services will also be provided for Substance Use Disorder Rehabilitation Treatment in a Residential Treatment Center. Substance Use Disorder Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with the Claim Administrator or in a Non-Administrator Provider facility will be paid at the Non-Administrator Provider facility payment level.

DETOXIFICATION

Covered Services received for detoxification are not subject to the Substance Use Disorder treatment provisions specified above. Benefits for Covered Services received for detoxification will be provided under the Hospital Benefits and Physician Benefits sections of this benefit booklet, the same as for any other condition.

MENTAL ILLNESS AND SUBSTANCE USE DISORDER SERVICES

Benefits for all of the Covered Services described in this benefit booklet are available for the diagnosis and/or treatment of a Mental Illness and/or Sub-

stance Use Disorder. Inpatient benefits for these Covered Services will also be provided for the diagnosis and/or treatment of Inpatient Mental Illness in a Residential Treatment Center. Treatment of a Mental Illness or Substance Use Disorder is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license. Covered Services rendered in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.

BARIATRIC SURGERY

Benefits for Covered Services received for bariatric Surgery will be provided under the Hospital Benefit and Physician Benefit sections of this benefit booklet, the same as for any other condition.

MATERNITY SERVICE

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one routine Inpatient examination and c) one Inpatient hearing screening as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth).

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from the Claim Administrator for prescribing a length of stay less than 48 hours (or 96 hours).

Your coverage also includes benefits for elective abortions if legal where performed.

INFERTILITY TREATMENT

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis and/or treatment of infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection.

Special Limitations

Benefits will not be provided for the following:

1. Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from you will be covered if you choose to use a surrogate.
2. Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term.
3. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.
4. Non-medical costs of an egg or sperm donor.
5. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary or required by the Claim Administrator.
6. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.
7. Infertility treatment rendered to your dependents under age 18.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.

Your benefits for Assisted Reproductive Technologies (ART) and all related services and supplies are subject to a lifetime maximum of \$20,000 for medical and prescription drugs combined. If you have Family Coverage, this is a family maximum.

Gamete intrafallopian tube transfer (GIFT) and zygote intrafallopian tube transfer (ZIFT) procedures must be reviewed through the Utilization Review Program before services are rendered. Should you fail to notify the Claim Administrator as required in the Utilization Review Program section, you will then be responsible for the first \$500 of the charges in addition to any deductibles, Copayments and/or Coinsurance applicable to this benefit booklet.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

Benefits for all of the Covered Services previously described in this benefit booklet are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

HEARING CARE

Benefits will be provided at 100% of the Claim Charge for one routine hearing examination per benefit period. Benefits will not be provided for hearing aids.

Benefits for unilateral or bilateral cochlear implants (CI) and associated aural rehabilitation will be provided at the payment levels previously described in this benefit booklet for Hospital and Physician Covered Services. Cochlear implantation must be Medically Necessary and can be an inpatient or outpatient procedure. Upgrades of existing components are Medically Necessary only for patients in whom response to existing components is inadequate to the point of interfering with the activities of daily living or when components are no longer functional.

MASTECTOMY-RELATED SERVICES

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are not limited to:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Inpatient care following a mastectomy for the length of time determined by your attending Physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within 48 hours after discharge; and
4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.
5. The removal of breast implants when the removal of the implants is a Medically Necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons is not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury are not considered cosmetic Surgery.

PAYMENT PROVISIONS

Lifetime Maximum

Your benefits are not subject to a lifetime maximum. The total dollar amount that will be available in benefits for you is unlimited subject to the separate dollar maximums for specific Covered Services described earlier in this benefit booklet.

OUT-OF-POCKET EXPENSE LIMIT

There are separate Out-of-Pocket Expense Limits applicable to Covered Services received from Participating Providers and Non-Participating Providers.

Individual Out-of-Pocket Expense Limits For Participating Providers**(Employees with a base salary of under \$100,000)**

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals \$2,600, any additional eligible Claims for Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

(Employees with a base salary of \$100,000 or over)

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals \$3,100, any additional eligible Claims for Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the Participating Provider program deductible
- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Participating or Non-Administrator Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Participating Provider or a Non-Administrator Provider
- charges for Covered Services which have a separate dollar maximum specifically mentioned in this benefit booklet
- charges for Outpatient prescription drugs
- Copayments resulting from noncompliance with the provisions of the Utilization Review Program and/or the Claim Administrator's Mental Health Unit
- and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed.

Family Out-of-Pocket Expense Limits for Participating Providers**(Employees with a base salary of under \$100,000)**

If you have Family Coverage and your expense as described above equals \$5,200 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the

Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

(Employees with a base salary of \$100,000 and over)

If you have Family Coverage and your expense as described above equals \$6,200 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

Individual Out-of-Pocket Expense Limits For Non-Participating Providers

(Employees with a base salary of under \$100,000)

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals \$5,000, any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

(Employees with a base salary of \$100,000 and over)

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals \$5,000, any additional eligible Claims for Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the Non-Participating Provider program deductible
- the payments for Covered Services rendered by a Non-Participating Provider for which you are responsible after benefits have been provided
- the Coinsurance resulting from Covered Services rendered by a Non-Administrator Hospital or other Non-Administrator Provider facility (For Non-Participating Providers: out-of-pocket expense only)

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services you may receive from a Participating Provider
- charges for Covered Services which have a separate dollar maximum specifically mentioned in this benefit booklet
- charges for Outpatient prescription drugs

- Copayments resulting from noncompliance with the provisions of the Utilization Review Program and/or the Claim Administrator's Mental Health Unit
- any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period.

Family Out-of-Pocket Expense Limits for Non-Participating Providers

All charges applied to the individual out-of-pocket expense amount will be applied towards the family out-of-pocket expense amount. Once a person meets their individual out-of-pocket-expense, no more out-of-pocket expense is required for that individual. When the family out-of-pocket expense amount is reached, no further out-of-pocket expense will have to be satisfied for the remainder of the benefit period. No participant will contribute more than the individual out-of-pocket expense amount to the family out-of-pocket expense amount.

(Employees with a base salary of under \$100,000)

If you have Family Coverage and your expense as described above equals \$10,000 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

(Employees with a base salary of \$100,000 and over)

If you have Family Coverage and your expense as described above equals \$10,000 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this plan is terminated, benefits will be provided for, and limited to, the Covered Services of this plan which are rendered by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Use Disorder Treatment Facility, Partial Hospitalization Treatment Program or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.

HOSPICE CARE PROGRAM

Your Hospital coverage also includes benefits for Hospice Care Program Service.

Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

1. Coordinated Home Care;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services – Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services;
10. Respite Care Service.

The following services are **not** covered under the Hospice Care Program:

1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
5. Transportation, including, but not limited to, Ambulance Transportation.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this benefit booklet.

Benefit Payment for Hospice Care Program Services

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same payment level as described for Inpatient Hospital Covered Services.

BENEFITS FOR MEDICARE ELIGIBLE COVERED PERSONS

This section describes the benefits which will be provided for Medicare Eligible Covered Persons who are not affected by MSP laws, unless otherwise specified in this benefit booklet (see provisions entitled “Medicare Eligible Covered Persons” in the ELIGIBILITY SECTION of this benefit booklet).

The benefits and provisions described throughout this benefit booklet apply to you, however, in determining the benefits to be paid for your Covered Services, consideration is given to the benefits available under Medicare.

The process used in determining benefits under the Health Care Plan is as follows:

1. determine what the payment for a Covered Service would be following the payment provisions of this coverage and
2. deduct from this resulting amount the amount paid or payable by Medicare. (If you are eligible for Medicare, the amount that is available from Medicare will be deducted whether or not you have enrolled and/or received payment from Medicare.) The difference, if any, is the amount that will be paid under the Health Care Plan.

When you have a Claim, you must send the Claim Administrator a copy of your Explanation of Medicare Benefits (“EOMB”) in order for your Claim to be processed. In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used.)

EXCLUSIONS - WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

— **Hospitalization, services and supplies which are not Medically Necessary.**

No benefits will be provided for services which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of the Claim Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
- Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.

The Claim Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your health care plan. In most instances this decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's decision, your plan provides for an appeal of that decision.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, THE CLAIM ADMINISTRATOR WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY.

- Services or supplies that are not specifically mentioned in this benefit booklet.
- Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.
- Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

- Services or supplies that do not meet accepted standards of medical and/or dental practice.
- Investigational Services and Supplies and all related services and supplies, except as may be provided under this benefit booklet for the cost of routine patient care associated with Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with an approved clinical trial program.
- Custodial Care Service.
- Long Term Care Service.
- Respite Care Service, except as specifically mentioned under the Hospice Care Program.
- Inpatient Private Duty Nursing Service.
- Routine physical examinations, unless otherwise specified in this benefit booklet.
- Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases, or otherwise meeting the Claim Administrator's medical policy.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Charges for failure to keep a scheduled visit or charges for completion of a Claim form.
- Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this benefit booklet.
- Blood derivatives which are not classified as drugs in the official formularies.
- Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the

refractive state of the eye, except as specifically mentioned in this benefit booklet.

- Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.
- Routine foot care, except for persons diagnosed with diabetes.
- Immunizations, unless otherwise specified in this benefit booklet.
- Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this benefit booklet.
- Maintenance Care.
- Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation.
- Hearing aids or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this benefit booklet.
- Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are covered separately under this Health Care Plan.
- Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this benefit booklet.
- Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
- Wigs (also referred to as cranial prostheses), unless otherwise specified in this benefit booklet.
- Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this benefit booklet.
- Reversals of sterilization.
- Acupuncture.
- Christian Science Providers.
- Smoking Cessation Treatment/Therapy.
- Hypnosis/Hypnotherapy.
- Non-Skilled Respite Care.
- Chelation therapy, except to treat heavy metal poisoning.

- Care for treatment to the teeth, gums, or supporting structures such as, but not limited to periodontal treatment, endodontic services, extractions, implants or any treatment to improve the ability to chew or speak.
- Services and supplies received from a clinic or medical/dental office maintained by an employer or union.
- Any treatment relating to GID if (i) such treatment does not conform to the WPATH Standards of Care for Gender Identity Disorder, (ii) such treatment is not an available treatment for the Covered Person's applicable stage of GID, or (iii) the Covered Person does not submit the required documentation to the Plan Administrator prior to receiving the treatment.
- Category III or Tracking CPT Codes.
- Residential Treatment Centers, except for Inpatient Substance Use Disorder Rehabilitation Treatment or Inpatient Mental Illness as specifically mentioned in this benefit booklet.

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies when you have health care coverage through more than one group program. The purpose of COB is to insure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claim Administrator of the existence of such other group coverages. COB does not apply to the Outpatient Prescription Drug Program Benefit Section.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

1. The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.
2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this "birthday" type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.
 - However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody;
 - when the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the step-parent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child. It is the obligation of the person claiming benefits to notify the Claim Administrator, and upon its request to provide a copy, of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

The Claim Administrator has the right in administering these COB provisions to:

- pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.
- recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person or other organization.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

For an explanation of the Continuation coverage rights under COBRA, please see the Summary Plan Description for the Participating Medical Plan under the Accenture Group Health Plan found in the Plan Information page on the Knowledge Library tab at the Live Well at Accenture website, <http://resources.hewitt.com/accenture>.

CONTINUATION OF COVERAGE FOR DOMESTIC PARTNERS

The purpose of this section of your benefit booklet is to explain the options available for temporarily continuing your coverage after termination, if you are covered under this benefit booklet as the Domestic Partner of an Eligible Person or as the dependent child of a Domestic Partner. Your continued coverage under this benefit booklet will be provided only as specified below. Please read the provisions very carefully.

Continuation of Coverage

If you are the Domestic Partner or the dependent child of a Domestic Partner and you lose coverage under this benefit booklet, you have the same options as the spouse or dependent child of an Eligible Person to continue your coverage. The options available to a spouse or a dependent child are described in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable to your Group.

NOTE: Certain employers may not be required to offer COBRA continuation coverage. See your Group Administrator if you have any questions about COBRA.

In addition to the events listed in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Domestic Partnership with the Eligible Person terminates. Your Domestic Partnership will terminate if your partnership no longer meets the criteria described in the definition of “Domestic Partnership” in the DEFINITIONS SECTION of this benefit booklet. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

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**CLAIM FILING AND
APPEALS PROCEDURES**

In order to obtain your benefits under this benefit program, it is necessary for a Claim to be filed with the Claim Administrator. To file a Claim, usually all you will have to do is show your ID card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember however, it is your responsibility to ensure that the necessary Claim information has been provided to the Claim Administrator.

Once the Claim Administrator receives your Claim, it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how your benefits were calculated. In some cases the Claim Administrator will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from your Employee Benefits Department or from the Claim Administrator's office.
2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge.
3. Mail the completed Claim Form with attachments to:

Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, Illinois 60680-4112

In any case, Claims must be filed no later than twelve months after the date a service is received. Claims not filed within twelve months from the date a service is received, will not be eligible for payment.

Should you have any questions about filing Claims, ask your Employee Benefits Department or call the Claim Administrator's office.

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIMS DETERMINATIONS

The Claim Administrator will usually pay all Claims within 30 days of receipt of all information required to process a Claim. The Claim Administrator will usually notify you, your valid assignee or your authorized representative, when all information required to pay a Claim within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provisions in the GENERAL PROVISIONS section of this benefit booklet.) If you fail to follow the

procedures for filing a pre-service claim (as defined below), you will be notified within 5 days (or within 24 hours in the case of a failure regarding an urgent care/expedited clinical claim [as defined below]). Notification may be oral unless the claimant requests written notification.

If a Claim Is Denied or Not Paid in Full

If a claim for benefits is denied in whole or in part, you will receive a notice from the Claim Administrator within the following time limits:

1. For non-urgent pre-service claims, within 15 days after receipt of the claim by the Claim Administrator. A “pre-service claim” is any non-urgent request for benefits or for a determination, with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
2. For post-service Claims, within 30 days after receipt of the Claim by the Claim Administrator. A “post-service claim” is a Claim as defined above.

If the Claim Administrator determines that special circumstances require an extension of time for processing the claim, for non-urgent pre-service and post-service claims, the Claim Administrator shall notify you or your authorized representative in writing of the need for extension, the reason for the extension, and the expected date of decision within the initial period. In no event shall such extension exceed 15 days from the end of such initial period. If an extension is necessary because additional information is needed from you, the notice of extension shall also specifically describe the missing information, and you shall have at least 45 days from receipt of the notice within which to provide the requested information.

If the claim for benefits is denied in whole or in part, you or your authorized representative shall be notified in writing of the following:

- a. The reasons for denial;
- b. A reference to the benefit plan provisions on which the denial is based;
- c. A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
- d. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), diagnosis, treatment and denial codes with their meanings and the standards used;
- e. An explanation of the Claim Administrator’s internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;

- f. In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other benefit information may be available in such non-English language(s);
 - g. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
 - h. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
 - i. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
 - j. In the case of a denial of an urgent care/expedited clinical claim, a description of the expedited review procedure applicable to such claims. An urgent care/expedited claim decision may be provided orally, so long as written notice is furnished to the claimant within 3 days of oral notification;
 - k. Contact information for applicable office of health insurance consumer assistance or ombudsman.
- 3. For benefit determinations relating to urgent care/expedited clinical claim (as defined below), such notice will be provided no later than 24 hours after the receipt of your claim for benefits, unless you fail to provide sufficient information. You will be notified of the missing information and will have no less than 48 hours to provide the information. A benefit determination will be made within 48 hours after the missing information is received.
 - 4. For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your claim for benefits.

An "urgent care/expedited clinical claim" is any pre-service claim for benefits for medical care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

INQUIRIES AND COMPLAINTS

An "**Inquiry**" is a general request for information regarding claims, benefits, or membership.

A **“Complaint”** is an expression of dissatisfaction by you either orally or in writing.

The Claim Administrator has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to, the following:

- Claims
- Quality of care

When your Complaint relates to dissatisfaction with a claim denial (or partial denial), then you have the right to a claim review/appeal as described in the CLAIM APPEAL PROCEDURES.

To pursue an Inquiry or a Complaint, you may contact **Customer Service** at the number on the back of your ID card, or you may write to:

**Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, Illinois 60601**

When you contact Customer Service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of receipt by Customer Service. Sometimes the acknowledgement and the response will be combined. If the Claim Administrator needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information, you will be contacted.

An appeal is an oral or written request for review of an Adverse Benefit Determination (as defined below) or an adverse action by the Claim Administrator, its employees or a participating provider.

CLAIM APPEAL PROCEDURES - DEFINITIONS

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your ID card.

An **“Adverse Benefit Determination”** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator or your Employer and the Claim Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination of the Employer’s benefit plan) before the end of the approved treatment period, that is also an Adverse

Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

In addition, an Adverse Benefit Determination, also includes an “Adverse Determination.” An **“Adverse Determination”** means a determination by the Claim Administrator or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a Covered Service has been reviewed and, based upon the information provided, does not meet the Claim Administrator’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. For purposes of this benefit program, we will refer to both an Adverse Determination and an Adverse Benefit Determination as an Adverse Benefit Determination, unless indicated otherwise.

A **“Final Internal Adverse Benefit Determination”** means an Adverse Benefit Determination that has been upheld by the Claim Administrator or your Employer at the completion of the Claim Administrator’s or Employer’s internal review/appeal process.

CLAIM APPEAL PROCEDURES

If you have received an Adverse Benefit Determination, you may have your Claim reviewed on appeal. The Claim Administrator will review its decision in accordance with the following procedures. The following review procedures will also be used for Claim Administrator’s (i) coverage determinations that are related to non-urgent care that you have not yet received if approval by your plan is a condition of your opportunity to maximize your benefits and (ii) coverage determinations that are related to care that you are receiving at the same time as the determination. Claim reviews are commonly referred to as “appeals.”

Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the Claim Administrator to request a claim review. The Claim Administrator will need to know the reasons why you do not agree with the Adverse Benefit Determination. You may call 1-877-284-9302 or send your request to:

Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690

In support of your Claim review, you have the option of presenting evidence and testimony to the Claim Administrator, by phone or in person at a location of the Claim Administrator’s choice. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the Claim review process.

The Claim Administrator will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of your Claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale and information will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. The appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors, but who were not involved in making the initial denial of your Claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator or your Employer.

Urgent Care/Expedited Clinical Appeals

If your appeal relates to an urgent care/expedited clinical claim, or health care services, including but not limited to, procedures or treatments ordered by a health care provider, the denial of which could significantly increase the risk to the claimant's health, then you may be entitled to an appeal on an expedited basis. Before authorization of benefits for an ongoing course of treatment is terminated or reduced, the Claim Administrator will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an urgent care/expedited pre-service or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Claim Administrator shall render a determination on the appeal within 24 hours after it receives the requested information.

Other Appeals

Upon receipt of a non-urgent pre-service or post-service appeal the Claim Administrator shall render a determination of the appeal within 30 days after the appeal has been received by the Claim Administrator or such other time as required or permitted by law.

You may also appeal the Claim Administrator's final adverse benefit determination by filing a second level appeal. You have 60 days following receipt of a final denial of post-service or pre-service claims to file a written appeal (appeals involving an urgent care claim should be initiated by telephone). For an explanation of your second level appeal rights and the procedure to file an appeal, please see the General Information Summary Plan Description found in the Plan Information page on the Knowledge Library tab at the Live Well at Accenture website, <http://resources.hewitt.com/accenture>.

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters at 1-800-538-8833. The Claim Administrator offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9431, or call the number on the back of your ID card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Notice of Appeal Determination

The Claim Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, orally of its determination followed-up by a written notice of the determination.

The written notice will include:

1. The reasons for the determination;
2. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), and information about how to obtain diagnosis, treatment and denial codes with their meanings;
4. An explanation of the Claim Administrator's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal;
5. In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other benefit information may be available in such non-English language(s);
6. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
7. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline,

protocol or other similar criterion will be provided free of charge on request;

8. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
9. A description of the standard that was used in denying the claim and a discussion of the decision.

If the Claim Administrator's or your Employer's decision is to continue to deny or partially deny your Claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the INDEPENDENT EXTERNAL REVIEW section below.

If an appeal is not resolved to your satisfaction, you may appeal the Claim Administrator's decision to the Illinois Department of Insurance. The Illinois Department of Insurance will notify the Claim Administrator of the appeal. The Claim Administrator will have 21 days to respond to the Illinois Department of Insurance.

Some of the operations of the Claim Administrator are regulated by the Illinois Department of Insurance. Filing an appeal does not prevent you from filing a Complaint with the Illinois Department of Insurance or keep the Illinois Department of Insurance from investigating a Complaint.

You must exercise the right to internal appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity. If you have an adverse appeal determination, you may file civil action in a state or federal court.

STANDARD EXTERNAL REVIEW

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO).

An "**Adverse Benefit Determination**" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator or your Employer and the Claim Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination of the Employer's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

A “**Final Internal Adverse Benefit Determination**” means an Adverse Benefit Determination that has been upheld by the Claim Administrator at the completion of the Claim Administrator’s internal review/appeal process.

1. **Request for external review.** Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review. If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
2. **Preliminary review.** Within 5 business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:
 - a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
 - b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
 - c. You have exhausted the Claim Administrator’s internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the **EXHAUSTION** section below for additional information and exhaustion of the internal appeal process; and
 - d. You or your authorized representative have provided all the information and forms required to process an external review.

You will be notified within 1 business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor’s Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

3. **Referral to Independent Review Organization.** When an eligible request for external review is completed within the time period allowed, Claim Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by

similar nationally-recognized accrediting organization. Moreover, the Claim Administrator will take action against bias and to ensure independence. Accordingly, the Claim Administrator must contract within at least (3) IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

- a. Utilization of legal experts where appropriate to make coverage determinations under the plan.
- b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
- c. Within 5 business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within 1 business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.
- d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within 1 business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO

must terminate the external review upon receipt of the notice from the Claim Administrator.

- e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
 - (1) Your medical records;
 - (2) The attending health care professional's recommendation;
 - (3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;
 - (4) The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
 - (5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - (6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
 - (7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claim Administrator and you or your authorized representative.
- g. The notice of final external review decision will contain:
 - (1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

- (2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - (3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 - (4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - (5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator and you or your authorized representative;
 - (6) A statement that judicial review may be available to you or your authorized representative; and
 - (7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
- h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. Reversal of plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claim Administrator immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

EXPEDITED EXTERNAL REVIEW

1. Request for expedited external review. Claim Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claim Administrator at the time you receive:

- a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would

jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in STANDARD EXTERNAL REVIEW section above.
3. **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process.

4. **Notice of final external review decision.** The Claim Administrator's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the STANDARD EXTERNAL REVIEW section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

EXHAUSTION

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the Claim Administrator to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

GENERAL PROVISIONS

1. CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Claim Administrator hereby informs you that it has contracts with certain Providers (“Administrator Providers”) in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under the Health Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

- receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claim Administrator was obligated to pay the Administrator Provider, or
- pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Administrator Providers other substantial allowances under the Claim Administrator's contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by the Claim Administrator as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet shall be based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage (“ADP”) applicable to your Claim or Claims. Your Employer has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how the Claim Administrator's separate financial arrangements with Providers work, please consider the following example:

- a. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is \$1,000. How is the \$1,000 bill paid?
- b. You personally will have to pay the deductible and Coinsurance amounts set out in your benefit booklet.
- c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital's Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the \$1,000 Hospital bill would be reduced by 30% to \$700 for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

- d. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the \$1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of \$700, or \$140. You should note that your 20% Coinsurance is based on the full \$1,000 Hospital bill, after it is reduced by the applicable ADP.
- e. After taking into account the deductible and Coinsurance amounts, the Claim Administrator will satisfy its portion of the Hospital bill. In most cases, the Claim Administrator has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money the Claim Administrator would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is \$1,000, your deductible has already been satisfied, and your Coinsurance is \$140, then the Claim Administrator has to satisfy the rest of the Hospital bill, or \$860. Assuming the Claim Administrator has a contract with the Hospital, the Claim Administrator will usually be able to satisfy the \$860 bill that remains after your Coinsurance and deductible, by paying less than \$860 to the Hospital, often substantially less than \$860. The Claim Administrator receives, and keeps for its own account, the difference between the \$860 bill and whatever the Claim Administrator ultimately pays under its contracts with Administrator Providers, and neither you nor your Employer are entitled to any part of these savings.

Other Blue Cross and Blue Shields' Separate Financial Arrangements with Providers

Blue Card

The Claim Administrator hereby informs you that other Blue Cross and Blue Shield Plans outside of Illinois ("Host Blue") may have contracts similar to the contracts described above with certain Providers ("Host Blue Providers") in their service area.

When you receive health care services through BlueCard outside of Illinois and from a Provider which does not have a contract with the Claim Administrator, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue passes on to the Claim Administrator.

To help you understand how this calculation would work, please consider the following example:

- a. Suppose you receive covered medical services for an illness while you are on vacation outside of Illinois. You show your identification card to the provider to let him or her know that you are covered by the Claim Administrator.

- b. The provider has negotiated with the Host Blue a price of \$80, even though the provider's standard charge for this service is \$100. In this example, the provider bills the Host Blue \$100.
- c. The Host Blue, in turn, forwards the claim to the Claim Administrator and indicates that the negotiated price for the covered service is \$80. The Claim Administrator would then base the amount you must pay for the service – the amount applied to your deductible, if any, and your coinsurance percentage – on the \$80 negotiated price, not the \$100 billed charge.
- d. So, for example, if your coinsurance is 20%, you would pay \$16 (20% of \$80), not \$20 (20% of \$100). You are not responsible for amounts over the negotiated price for a covered service.

PLEASE NOTE: The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this benefit booklet.

Often, this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that factors into the actual price increases or reductions to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, the Claim Administrator would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Servicing Plans

In some instances, the Claim Administrator has entered into agreements with other Blue Cross and Blue Shield Plans (“Servicing Plans”) to provide, on the Claim Administrator's behalf, Claim Payments and certain administrative services for you. Under these agreements, the Claim Administrator will reimburse each Servicing Plan for all Claim Payments made on the Claim Administrator's behalf for you.

Certain Servicing Plans may have contracts similar to the contracts described above with certain Providers (“Servicing Plan Providers”) in their service area. The Servicing Plan will process your claim in accordance with the Servicing Plan’s applicable contract with the Servicing Plan Provider. Further, all amounts payable to the Servicing Plan by the Claim Administrator for Claim Payments made by the Servicing Plan and applicable service charges, and all benefit maximum amounts and any required deductible and Coinsurance amounts under this Health Care Plan will be calculated on the basis of the Servicing Plan Provider’s Eligible Charge for Covered Services rendered to you or the cost agreed upon between the Servicing Plan and the Claim Administrator for Covered Services that the Servicing Plan passes to the Claim Administrator, whichever is lower.

Often, the agreed upon cost is a simple discount. Sometimes, however, the agreed upon cost may represent either an estimated discount or an average discount received or expected by the Servicing Plan based on separate financial arrangements with Servicing Plan Providers.

In other instances, laws in a small number of states dictate the basis upon which the Coinsurance is calculated. When Covered Services are rendered in those states, the Coinsurance amount will be calculated using the state’s statutory method.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

- a. Under this Health Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. The Claim Administrator is specifically authorized by you to determine to whom any benefit payment should be made.
- b. Once Covered Services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.
- c. A Covered Person’s claim for benefits under this Health Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person. Coverage under this Health Care Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

3. YOUR PROVIDER RELATIONSHIPS

- a. The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.

- b. The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.
- c. The use of an adjective such as Participating, Administrator or approved in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Participating, Administrator, approved or any similar modifier or the use of a term such as Non-Administrator or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.
- d. Each Provider provides Covered Services only to you and does not deal with or provide any services to your Employer (other than as an individual Covered Person) or your Employer's ERISA Health Benefit Program.

4. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Health Care Plan as described in this benefit booklet must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this benefit booklet for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator's records or in care of your Employer and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

5. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Health Care Plan as described in this benefit booklet, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet.

6. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, hav-

ing knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under the Health Care Plan, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Claim Administrator or its agent, and agree that any such Provider, person or other entity may furnish to the Claim Administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Claim Administrator may furnish similar information and records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish the Claim Administrator and/or your Employer or group administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the Claim Administrator be able to make Claim Payments in accordance with MSP laws.

REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to negligence of a third party and benefits are provided for Covered Services described in this benefit booklet, you agree:

- a. the Claim Administrator has the rights to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which the Claim Administrator has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.
- b. the Claim Administrator is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Claim Administrator provided for that sickness or injury.

The Claim Administrator shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses for which the Claim Administrator has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability. (See provisions of this benefit booklet regarding "Claim Administrator's Separate Financial Arrangements with Providers.")

Administered by:



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.™

ASO-1

Effective Date: January 1, 2014

www.bcbsil.com

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Illinois provides administrative services only and
does not assume any financial risk or obligation with respect to claims.

EXHIBIT E

Your Health Care Benefit Program



BRG Sports, Inc.
Premier Plan – 018640

Administered by:



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.™

ELIGIBILITY SECTION INSERT**All American Riddell**

018639, 018640, 018641, 015945

Coverage Date

The Coverage Date for a person who becomes an Eligible Person after the effective date of the Employer's Health Care Plan is the first day of the month following 30 days of employment for all employees except factory hourly employees. The Coverage Date for factory hourly employees is the first day of the month following 90 days of employment.

Effective Date of Termination

The effective date of termination is the end of the month in which the member ceases to meet the definition of an Eligible Person. All members are covered until midnight of the day the member no longer meets the definition of an Eligible Person.

BRG Sports, Inc.

018645, 018646, 015967, 018647, 018648

Coverage Date

The Coverage Date for a person who becomes an Eligible Person after the effective date of the Employer's Health Care Plan is the first day of the month following 30 days of employment for all employees.

Effective Date of Termination

The effective date of termination is the end of the month in which the member ceases to meet the definition of an Eligible Person. All members are covered until midnight of the day the member no longer meets the definition of an Eligible Person.

Riddell Sports

018642, 018643, 018644, 015946

Coverage Date

The Coverage Date for a person who becomes an Eligible Person after the effective date of the Employer's Health Care Plan is the first day of the month following 30 days of employment for all employees.

Effective Date of Termination

The effective date of termination is the end of the month in which the member ceases to meet the definition of an Eligible Person. All members are covered until midnight of the day the member no longer meets the definition of an Eligible Person.

ELIGIBILITY SECTION INSERT**BRG Sports, Inc.**

016063, 016064

Coverage Date

The Coverage Date for a person who becomes an Eligible Person after the effective date of the Employer's Health Care Plan is the first day of the month following 30 days of employment for all employees except York Union and factory hourly employees. The Coverage Date for York Union employees is the sixty-first(61st) day of the month following the first day of employment. The Coverage Date for factory hourly employees is the first day of the month following 90 days of employment.

Effective Date of Termination Except for York Union

The effective date of termination is the end of the month in which the member ceases to meet the definition of an Eligible Person. All members are covered until midnight of the day the member no longer meets the definition of an Eligible Person.

Effective Date of Termination for York Union

The effective date of termination is the date the member ceases to meet the definition of an Eligible Person. All members are covered until midnight of the day the member no longer meets the definition of an Eligible Person.

A message from

BRG Sports, Inc.

This booklet describes the Health Care Plan which we provide to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your health care claims, we have engaged Blue Cross and Blue Shield of Illinois as Claim Administrator.

Please read the information in this benefit booklet carefully so you will have a full understanding of your health care benefits. If you want more information or have any questions about your health care benefits, please contact the Employee Benefits Department.

Sincerely,

BRG Sports, Inc.

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NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those Providers.

Please refer to the provision entitled “Claim Administrator’s Separate Financial Arrangements with Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Please note that the Claim Administrator has contracts, either directly or indirectly, with many prescription drug providers that provide the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those providers.

Please refer to the provision entitled “Claim Administrator’s Separate Financial Arrangements with Prescription Drug Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Blue Cross and Blue Shield of Illinois provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

**WARNING, LIMITED BENEFITS WILL BE PAID WHEN
NON-PARTICIPATING PROVIDERS ARE USED**

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy’s fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the plan. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED UNDER THIS COVERAGE AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

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BENEFIT HIGHLIGHTS

Your health care benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire benefit booklet.

THE UTILIZATION REVIEW PROGRAM

A special program designed to assist you in determining the course of treatment that will maximize your benefits under this benefit booklet

Lifetime Maximum
for all Benefits

Unlimited

Individual Deductible

- Participating Provider \$500 per benefit period
- Non-Participating and
Non-Administrator Provider \$2,000 per benefit period

Family Deductible

- Participating Provider \$1,500 per benefit period
- Non-Participating and
Non-Administrator Provider \$4,500 per benefit period

Individual Out-of-Pocket
Expense Limit

(does not apply to all services)

- Participating Provider \$1,500 per benefit period
- Non-Participating Provider \$4,500 per benefit period
- Non-Administrator Provider No limit

Family Out-of-Pocket
Expense Limit

- Participating Provider \$4,500 per benefit period
- Non-Participating Provider \$13,500 per benefit period
- Non-Administrator Provider No limit

Private Duty Nursing Service

Benefit Maximum 60 visits per benefit period

Chiropractic and Osteopathic

Manipulation Benefit Maximum 35 visits per benefit period

Physical Therapy Services

Benefit Maximum 60 visits per benefit period

Occupational Therapy

Benefit Maximum 60 visits per benefit period

Speech Therapy

Benefit Maximum 60 visits per benefit period

HOSPITAL BENEFITS

Payment level for Covered
Services from a

Participating Provider:

- Inpatient Covered Services 80% of the Eligible Charge
- Outpatient Covered Services 80% of the Eligible Charge
- Urgent Care \$40 Copayment, then 100% of the Eligible Charge

Payment level for Covered
Services from a

Non-Participating Provider:

- Inpatient Covered Services 70% of the Eligible Charge
- Outpatient Covered Services 70% of the Eligible Charge

Payment level for Covered
Services from a

Non-Administrator Provider

50% of the Eligible Charge

Hospital Emergency Care

- Payment level for Emergency Accident Care from either a Participating, Non-Participating or Non-Administrator Provider 100% of the Eligible Charge, no deductible
- Payment level for Emergency Medical Care from either a Participating, Non-Participating or Non-Administrator Provider 100% of the Eligible Charge, no deductible

Emergency Room

\$150 Copayment
(waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)

PHYSICIAN BENEFITS

Payment level for Surgical/
Medical Covered Services

- **Participating Provider** 80% of the Maximum Allowance
- **Non-Participating Provider** 70% of the Maximum Allowance

Payment level for
Covered Services received in a
Professional Provider's Office

- Participating Provider (other than a specialist) \$25 per visit, then 100% of the Maximum Allowance, no deductible
- Participating Provider Specialist \$40 per visit, then 100% of the Maximum Allowance, no deductible

Payment level for Emergency
Accident Care

100% of the Maximum Allowance,
no deductible

Payment level for Emergency
Medical Care

100% of the Maximum Allowance,
no deductible

OTHER COVERED SERVICES

Payment level

70% of the Eligible Charge
or Maximum Allowance

PRESCRIPTION DRUG PROGRAM BENEFITS

Individual Out-of-Pocket

\$1,500 per benefit period

Family Out-of-Pocket

\$4,500 per benefit period

Copayment

- generic drugs \$15 per prescription

- Formulary brand name drugs and all diabetic supplies \$40 per prescription

- non-Formulary brand name drugs \$60 per prescription

- self-injectable drugs other than insulin drugs \$60 per prescription

Home Delivery Prescription
Drug Program

Copayment

- generic drugs \$25 per prescription

- Formulary brand name drugs and all diabetic supplies \$85 per prescription

- non-Formulary brand name drugs \$135 per prescription

- self-injectable drugs other than insulin and infertility drugs \$135 per prescription

TO IDENTIFY NON-ADMINISTRATOR AND ADMINISTRATOR HOSPITALS OR FACILITIES, YOU SHOULD CONTACT THE CLAIM ADMINISTRATOR BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR IDENTIFICATION CARD.

DEFINITIONS SECTION

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

ADMINISTRATOR PROGRAM.....means programs for which a Hospital has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time services are rendered to you. These programs are limited to a Partial Hospitalization Treatment Program or Coordinated Home Care Program.

ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

ADVANCED PRACTICE NURSE.....means Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist.

AMBULANCE TRANSPORTATION.....means local transportation in a specially equipped certified vehicle from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.

AMBULATORY SURGICAL FACILITY.....means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

An "Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which does not meet the definition of an Administrator Ambulatory Surgical Facility.

ANESTHESIA SERVICES.....means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them respectively.

AUTISM SPECTRUM DISORDER(S).....means pervasive developmental disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, including autism, Asperger's disorder and pervasive developmental disorders not otherwise specified.

AVERAGE DISCOUNT PERCENTAGE ("ADP").....means a percentage discount determined by the Claim Administrator that will be applied to a Provider's Eligible Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by the Claim Administrator to be relevant to the particular Claim. The ADP reflects the Claim Administrator's reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect related costs. (See provisions of this benefit booklet regarding "Claim Administrator's Separate Financial Arrangements with Providers.") In determining the ADP applicable to a particular Claim, the Claim Administrator will take into account differences among Hospitals and other facilities, the Claim Administrator's contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when your benefits under the Health Care Plan are secondary to Medicare and/or coverage under any other group program.

BEHAVIORAL HEALTH PRACTITIONER.....means a Physician or Professional Provider who is duly licensed to render services for Mental Illness, Serious Mental Illness or Substance Use Disorder.

CERTIFICATE OF CREDITABLE COVERAGE.....means a certificate disclosing information relating to your Creditable Coverage under a health care benefit program.

CERTIFIED CLINICAL NURSE SPECIALIST.....means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- (ii) is a graduate of an advanced practice nursing program.

A “Participating Certified Clinical Nurse Specialist” means a Certified Clinical Nurse Specialist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Clinical Nurse Specialist” means a Certified Clinical Nurse Specialist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE-MIDWIFE.....means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- (ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

A “Participating Certified Nurse-Midwife” means a Certified Nurse-Midwife who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Nurse-Midwife” means a Certified Nurse-Midwife who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE PRACTITIONER.....means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- (ii) is a graduate of an advanced practice nursing program.

A “Participating Certified Nurse Practitioner” means a Certified Nurse Practitioner who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Nurse Practitioner” means a Certified Nurse Practitioner who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED REGISTERED NURSE ANESTHETIST or CRNA.....means a nurse anesthetist who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

A “Participating Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CHEMOTHERAPY.....means the treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

CHIROPRACTOR.....means a duly licensed chiropractor.

CLAIM.....means notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

CLAIM ADMINISTRATOR.....means Blue Cross and Blue Shield of Illinois.

CLAIM CHARGE.....means the amount which appears on a Claim as the Provider’s charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding “The Claim Administrator’s Separate Financial Arrangements with Providers.”)

CLAIM PAYMENT.....means the benefit payment calculated by the Claim Administrator, after submission of a Claim, in accordance with the benefits described in this benefit booklet. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding “The Claim Administrator’s Separate Financial Arrangements with Providers.”)

CLINICAL LABORATORY.....means a clinical laboratory which complies with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, the Medicare and Medicaid programs and any applicable state and local statutes and regulations.

A “Participating Clinical Laboratory” means a Clinical Laboratory which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Laboratory” means a Clinical Laboratory which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan provide services to you at the time services are rendered.

CLINICAL PROFESSIONAL COUNSELOR.....means a duly licensed clinical professional counselor.

A “Participating Clinical Professional Counselor” means a Clinical Professional Counselor who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Professional Counselor” means a Clinical Professional Counselor who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL SOCIAL WORKER.....means a duly licensed clinical social worker.

A “Participating Clinical Social Worker” means a Clinical Social Worker who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Social Worker” means a Clinical Social Worker who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this program.

COINSURANCE.....means a percentage of an eligible expense that you are required to pay towards a Covered Service.

COMPLICATIONS OF PREGNANCY.....means all physical effects suffered as a result of pregnancy which would not be considered the effect of normal pregnancy.

CONGENITAL OR GENETIC DISORDER.....means a disorder that includes, but is not limited to, hereditary disorders. Congenital or Genetic Disorders may also include, but is not limited to, Autism or an Autism Spectrum Disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma or injury.

COORDINATED HOME CARE PROGRAM.....means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

An "Administrator Coordinated Home Care Program" means a Coordinated Home Care Program which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time service is rendered to you.

A "Non-Administrator Coordinated Home Care Program" means a Coordinated Home Care Program which does not have an agreement with the Claim Administrator or a Blue Cross Plan but has been certified as a home health agency in accordance with the guidelines established by Medicare.

COPAYMENT.....means a specified dollar amount that you are required to pay towards a Covered Service.

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE.....means the date on which your coverage under the Health Care Plan begins.

COVERED SERVICE.....means a service and supply specified in this benefit booklet for which benefits will be provided.

CREDITABLE COVERAGE.....means coverage you had under any of the following:

- (i) a group health plan.
- (ii) Health insurance coverage for medical care under any hospital or medical service policy plan, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.
- (iii) Medicare (Parts A or B of Title XVIII of the Social Security Act).
- (iv) Medicaid (Title XIX of the Social Security Act).
- (v) Medical care for members and certain former members of the uniformed services and their dependents.
- (vi) A medical care program of the Indian Health Service or of a tribal organization.
- (vii) A State health benefits risk pool.
- (viii) A health plan offered under the Federal Employees Health Benefits Program.
- (ix) A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country.
- (x) A health plan under Section 5(e) of the Peace Corps Act.
- (xi) State Children's Health Insurance Program (Title XXI of the Social Security Act).

CUSTODIAL CARE SERVICE.....means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you.

DENTIST.....means a duly licensed dentist.

DIAGNOSTIC SERVICE.....means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

DIALYSIS FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

An “Administrator Dialysis Facility” means a Dialysis Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Dialysis Facility” means a Dialysis Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with the guidelines established by Medicare.

DOMESTIC PARTNER.....means a person with whom you have entered into a Domestic Partnership.

DOMESTIC PARTNERSHIP.....means long-term committed relationship of indefinite duration with a person of the same sex which meets the following criteria:

- (i) you and your Domestic Partner have lived together for at least 6 months,
- (ii) neither you nor your Domestic Partner is married to anyone else or has another domestic partner,
- (iii) your Domestic Partner is at least 18 years of age and mentally competent to consent to contract,
- (iv) your Domestic Partner resides with you and intends to do so indefinitely,
- (v) you and your Domestic Partner have an exclusive mutual commitment similar to marriage, and
- (vi) you and your Domestic Partner are not related by blood closer than would bar marriage in the state of your legal residence (i.e., the blood relationship is not one which would forbid marriage in the state of your residence, if you and the Domestic Partner were of the opposite sex).

You and your Domestic Partner must be jointly responsible for each other’s common welfare and must share financial obligations. Joint responsibility may be demonstrated by the existence of at least 3 of the following: a signed Affidavit of Domestic Partnership, a joint mortgage or lease, designation of you or your Domestic Partner as a beneficiary in the other partner’s life insurance and retirement contract, designation of you or your Domestic Partner as the primary beneficiary in your or your Domestic Partner’s will, durable property and health care powers of attorney, or joint ownership of a motor vehicle, checking account or credit account.

DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider.

A “Participating Durable Medical Equipment Provider” means a Durable Medical Equipment Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Durable Medical Equipment Provider” means a Durable Medical Equipment Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

EARLY ACQUIRED DISORDER.....means a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking or self-help skills. Early Acquired Disorder may include, but is not limited to, Autism or an Autism Spectrum Disorder and cerebral palsy.

ELIGIBLE CHARGE.....means (a) in the case of a Provider, other than a Professional Provider, which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, such Provider’s Claim Charge for Covered Services and (b) in the case of a Provider, other than a Professional Provider, which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, will be the lesser of:

- (i) the Provider’s billed charges, or;
- (ii) the Claim Administrator non-contracting Eligible Charge. Except as otherwise provided in this section, the non-contracting Eligible Charge is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Eligible Charge for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating or Non-Administrator Provider’s standard billed charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Eligible Charge for Non-Participating or Non-Administrator Providers will be 50% of the Non-Participating or Non-Administrator Provider’s standard billed charge for such Covered Service.

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Provider Claims for processing

Claims submitted by Non-Participating or Non-Administrator Providers which may also alter the Eligible Charge for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

ELIGIBLE PERSON.....means an employee of the Employer who meets the eligibility requirements for this health and/or dental coverage, as described in the **ELIGIBILITY SECTION** of this benefit booklet.

EMERGENCY ACCIDENT CARE.....means the initial Outpatient treatment of accidental injuries including related Diagnostic Services. The initial Outpatient treatment does not include surgical procedures, including but not limited to, stitching, gluing and casting.

EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (ii) serious impairment to bodily functions; or
- (iii) serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION.....means an admission for the treatment of Mental Illness or Substance Use Disorders as a result of the sudden and unexpected onset of a Mental Illness or Substance Use Disorders condition such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

EMPLOYER.....means the company with which you are employed.

ENROLLMENT DATE.....means the first day of coverage under your Employer's health plan or, if your Employer has a waiting period prior to the effective date of your coverage, the first day of the waiting period (typically, the date employment begins).

FAMILY COVERAGE.....means coverage for you and your eligible dependents under the Health Care Plan.

HABILITATIVE SERVICES.....means Occupational Therapy, Physical Therapy, Speech Therapy, and other services prescribed by a Physician pursuant to a treatment plan to enhance the ability of a child to function with a Congenital, Genetic, or Early Acquired Disorder.

HOME INFUSION THERAPY PROVIDER.....means a duly licensed home infusion therapy provider.

A "Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

HOSPICE CARE PROGRAM PROVIDER.....means an organization duly licensed to provide Hospice Care Program Service.

HOSPICE CARE PROGRAM SERVICE.....means a centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility or special hospice care unit.

HOSPITAL.....means a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

An "Administrator Hospital" means a Hospital which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Hospital" means a Hospital that does not meet the definition of an Administrator Hospital.

A “Participating Hospital” means an Administrator Hospital that has an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide Hospital services to participants in the Participating Provider Option program.

A “Non-Participating Hospital” means an Administrator Hospital that does not meet the definition of a Participating Hospital.

INDIVIDUAL COVERAGE.....means coverage under the Health Care Plan for yourself but not your spouse and/or dependents.

INPATIENT.....means that you are a registered bed patient and are treated as such in a health care facility.

INVESTIGATIONAL or INVESTIGATIONAL SERVICES AND SUPPLIES.....means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

LONG TERM CARE SERVICES.....means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury or condition.

MAINTENANCE CARE.....means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY.....means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

MARRIAGE AND FAMILY THERAPIST (“LMFT”).....means a duly licensed marriage and family therapist.

A “Participating Marriage and Family Therapist” means a Marriage and Family Therapist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Marriage and Family Therapist” means a Marriage and Family Therapist who does not have a written agreement with the

Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

MATERNITY SERVICE.....means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

MAXIMUM ALLOWANCE.....means (a) the amount which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Professional Providers will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. (b) For Non-Participating Professional Providers, the Maximum Allowance will be the lesser of:

- (i) the Provider's billed charges, or;
- (ii) the Claim Administrator non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Maximum Allowance for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating Professional Provider's standard billed charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Maximum Allowance for Non-Participating Professional Providers will be 50% of the Non-Participating Professional Provider's standard billed charge for such Covered Service.

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Professional Provider Claims for processing Claims submitted by Non-Participating Professional Providers which may also alter the Maximum Allowance for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

MEDICAL CARE.....means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

MEDICALLY NECESSARY.....SEE EXCLUSIONS SECTION OF THIS BENEFIT BOOKLET.

MEDICARE.....means the program established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.).

MEDICARE APPROVED or MEDICARE PARTICIPATING.....means a Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

MEDICARE SECONDARY PAYER or MSP.....means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

MENTAL HEALTH UNIT.....means a unit established to assist in the administration of Mental Illness and Substance Use Disorder Rehabilitation Treatment benefits including Preauthorization, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for Inpatient Hospital admissions for the treatment of Mental Illness and Substance Use Disorder.

MENTAL ILLNESS.....means those illnesses classified as disorders in the current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

“Serious Mental Illness”.....means the following mental disorders as classified in the current *Diagnostic and Statistical Manual* published by the American Psychiatric Association:

- (i) Schizophrenia;
- (ii) Paranoid and other psychotic disorders;
- (iii) Bipolar disorders (hypomanic, manic, depressive and mixed);
- (iv) Major depressive disorders (single episode or recurrent);
- (v) Schizoaffective disorders (bipolar or depressive);
- (vi) Pervasive developmental disorders;

- (vii) Obsessive-compulsive disorders;
- (viii) Depression in childhood and adolescence;
- (ix) Panic disorder;
- (x) Post-traumatic stress disorders (acute, chronic, or with delayed onset); and
- (xi) Anorexia nervosa and bulimia nervosa.

NAPRAPATH.....means a duly licensed naprapath.

NAPRAPATHIC SERVICES.....means the performance of naprapathic practice by a Naprapath which may legally be rendered by them.

NON-ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

OCCUPATIONAL THERAPIST.....means a duly licensed occupational therapist.

OCCUPATIONAL THERAPY.....means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

OPTOMETRIST.....means a duly licensed optometrist.

A “Participating Optometrist” means an Optometrist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Optometrist” means an Optometrist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ORTHOTIC PROVIDER.....means a duly licensed orthotic provider.

A “Participating Orthotic Provider” means an Orthotic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/

or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Orthotic Provider” means an Orthotic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PARTIAL HOSPITALIZATION TREATMENT PROGRAM.....means a Claim Administrator approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Rehabilitation Treatment in which patients spend days or nights.

PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

PARTICIPATING PRESCRIPTION DRUG PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER OPTION.....means a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

PHARMACY.....means any licensed establishment in which the profession of pharmacy is practiced.

PHYSICAL THERAPIST.....means a duly licensed physical therapist.

PHYSICAL THERAPY.....means the treatment of a disease, injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider.

PODIATRIST.....means a duly licensed podiatrist.

PREAUTHORIZATION, PREAUTHORIZE or EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION REVIEW.....means a submission of a request to the Mental Health Unit for a determination of Medically Necessary care under this benefit booklet.

PRIVATE DUTY NURSING SERVICE.....means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PROSTHETIC PROVIDER.....means a duly licensed prosthetic provider.

A “Participating Prosthetic Provider” means a Prosthetic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Prosthetic Provider” means a Prosthetic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you.

An “Administrator Provider” means a Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Provider” means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.

A “Participating Provider” means an Administrator Hospital or Professional Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or an Administrator facility which has been designated by the Claim Administrator as a Participating Provider.

A “Non-Participating Provider” means an Administrator Hospital or Professional Provider which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or a facility which has not been designated by the Claim Administrator as a Participating Provider.

A “Professional Provider” means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist or any Provider designated by the Claim Administrator or another Blue Cross and/or Blue Shield Plan.

A “Participating Prescription Drug Provider” means a Pharmacy that has a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer its prescription drug program to provide services to you at the time you receive the services.

PSYCHOLOGIST.....means a Registered Clinical Psychologist.

Registered Clinical Psychologist means a Clinical Psychologist who is registered with the Illinois Department of Financial and Professional Regulation pursuant to the Illinois “Psychologists Registration Act” or, in a state where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program; or

is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

REGISTERED SURGICAL ASSISTANT.....means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant.

A “Participating Registered Surgical Assistant” means a Registered Surgical Assistant who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Registered Surgical Assistant” means a Registered Surgical Assistant who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

RENAL DIALYSIS TREATMENT.....means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

RESIDENTIAL TREATMENT CENTER.....means a facility setting offering therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision and structure and is licensed by the appropriate state and local authority to provide such service. It does not include halfway houses, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with Mental Illness and/or Substance Use Disorders.

RESPIRE CARE SERVICE.....means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services to you.

RETAIL HEALTH CLINIC.....means a health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by Certified Nurse Practitioners.

A "Participating Retail Health Clinic" means a Retail Health Clinic which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Retail Health Clinic" means a Retail Health Clinic which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

SKILLED NURSING FACILITY.....means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

An "Administrator Skilled Nursing Facility" means a Skilled Nursing Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Skilled Nursing Facility" means a Skilled Nursing Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with guidelines established by Medicare.

An "Uncertified Skilled Nursing Facility" means a Skilled Nursing Facility which does not meet the definition of an Administrator Skilled Nursing Fa-

cility and has not been certified in accordance with the guidelines established by Medicare.

SKILLED NURSING SERVICE.....means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

SPEECH THERAPIST.....means a duly licensed speech therapist.

SPEECH THERAPY.....means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

SUBSTANCE USE DISORDER.....means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Behavioral Health Practitioner, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

SUBSTANCE USE DISORDER TREATMENT FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment of Substance Use Disorder and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

An "Administrator Substance Use Disorder Treatment Facility" means a Substance Use Disorder Treatment Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Substance Use Disorder Treatment Facility” means a Substance Use Disorder Treatment Facility that does not meet the definition of an Administrator Substance Use Disorder Treatment Facility.

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claim Administrator.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

TOTALLY DISABLED.....means with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

ELIGIBILITY SECTION

This benefit booklet contains information about the health care benefit program for the persons who:

- Meet the definition of an Eligible Person as determined by your Employer;
- Have applied for this coverage; and
- Have received an identification card.

If you meet this description of an Eligible Person, you are entitled to the benefits of this program.

MEDICARE ELIGIBLE COVERED PERSONS

If you meet the definition of an Eligible Person stated in the ELIGIBILITY Section above and you are eligible for Medicare and not affected by the “Medicare Secondary Payer” (MSP) laws as described below, the benefits described in the section of this benefit booklet entitled “Benefits for Medicare Eligible Covered Persons” will apply to you and to your spouse and covered dependent children (if he or she is also eligible for Medicare and not affected by the MSP laws). This section does not apply to a Domestic Partner of the Eligible Person and their children.

A series of federal laws collectively referred to as the “Medicare Secondary Payer” (MSP) laws regulate the manner in which certain employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, dependent children.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer group health plan (“GHP”) coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

1. GHPs that cover individuals with end-stage renal disease (“ESRD”) during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has “current employment status.”
2. In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual’s spouse (of any age) has “current employment status.” If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).
3. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual’s family has “current employee status.” If the GHP is a multi-employer or multiple employer plan, which has at least one parti-

cipating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

PLEASE NOTE: SEE YOUR EMPLOYER OR GROUP ADMINISTRATOR SHOULD YOU HAVE ANY QUESTIONS REGARDING THE ESRD PRIMARY PERIOD OR OTHER PROVISIONS OF MSP LAWS AND THEIR APPLICATION TO YOU, YOUR SPOUSE OR ANY DEPENDENTS.

YOUR MSP RESPONSIBILITIES

In order to assist your employer in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from the Claim Administrator and/or your employer regarding the Medicare eligibility of you, your spouse and covered dependent children. In addition, if you, your spouse or covered dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact your employer or your group administrator promptly to ensure that your Claims are processed in accordance with applicable MSP laws.

YOUR ID CARD

You will receive an identification card. This card will tell you your identification number and will be very important to you in obtaining your benefits.

INDIVIDUAL COVERAGE

If you have Individual Coverage, only your own expenses for Covered Services are covered, not the expenses of other members of your family.

FAMILY COVERAGE

Child(ren) used hereafter, means a natural child(ren), a stepchild(ren), an adopted child(ren) who is in your custody under an interim court order of adoption or who is placed with you for adoption vesting temporary care.

If you have Family Coverage, your health expenses for Covered Services and those of your enrolled spouse and your (or your spouse's) enrolled children up to age 26 will be covered. The coverage for children will end on the last day of the month in which the limiting age is reached.

Your enrolled Domestic Partner and his or her enrolled children who have not attained the limiting age stated above will be covered. Whenever the term "spouse" is used, we also mean Domestic Partner. All of the provisions of this benefit booklet that pertain to a spouse also apply to a Domestic Partner, unless specifically noted otherwise.

Any newborn children will be covered from the moment of birth. Please notify your Group Administrator within 31 days of the date of birth so that your membership records can be adjusted.

Any children who are incapable of self-sustaining employment and are dependent upon you or other care providers for lifetime care and supervision because of a handicapped condition occurring prior to reaching the limiting

age will be covered regardless of age if they were covered prior to reaching the limiting age stated above.

Any children who are under your legal guardianship or who are in your custody under an interim court order of adoption or who are placed with you for adoption vesting temporary care will be covered.

This coverage does not include benefits for grandchildren (unless such children are under your legal guardianship) or foster children.

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE OR ADDING DEPENDENTS TO FAMILY COVERAGE

You can change from Individual to Family Coverage or add dependents to your Family Coverage because of any of the following events:

- Marriage.
- Establishment of a Domestic Partnership.
- Birth, adoption or placement for adoption of a child.
- Obtaining legal guardianship of a child.
- Loss of eligibility for other health coverage for you or your dependent if:
 - a. The other coverage was in effect when you were first eligible to enroll for this coverage;
 - b. The other coverage is not terminating for cause (such as failure to pay premiums or making a fraudulent claim); and
 - c. Where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment in this coverage.

This includes, but is not limited to, loss of coverage due to:

- a. Legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, or reduction in the number of hours of employment;
- b. In the case of HMO, coverage is no longer provided because an individual no longer resides in the service area or the HMO no longer offers coverage in the HMO service area in which the individual resides;
- c. Reaching a lifetime limit on all benefits in another group health plan;
- d. Another group health plan no longer offering any benefits to the class of similarly situated individuals that includes you or your dependent;
- e. When Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- f. When you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

When Coverage Begins

Your Family Coverage or the coverage for your additional dependents will be effective from the date of the event if you apply for this change within 31 days of any of the following events:

- Marriage.
- Establishment of a Domestic Partnership.
- Birth, adoption, or placement of adoption of a child.
- Obtaining legal guardianship of a child.

Your Family Coverage or the coverage for your additional dependents will be effective from the date you apply for coverage if you apply within 31 days of any of the following events:

- Loss of eligibility for other coverage for you or your dependent, except for loss of coverage due to reaching a lifetime limit on all benefits.
- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

If coverage is lost in another group health plan because a lifetime limit on all benefits is reached under that coverage and you apply for Family Coverage or to add dependents within 31 days after a claim is denied due to reaching the lifetime limit, your Family Coverage or the coverage for your additional dependents will be effective from the date your claim was denied.

Your Family Coverage or the coverage for your additional dependents will be effective from the date of the event if you apply for this change within 60 days of any of the following events:

- Loss of eligibility for you or your dependents when Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or
- You or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You must request this special enrollment within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. Coverage will be effective no later than the first of the month after the special enrollment request is received.

Late Applicants

If you do not apply for Family Coverage or to add dependents within the required number of days of the event, you will have to wait until your Employer's annual open enrollment period to make those changes. Such changes will be effective on a date that has been mutually agreed to by your Employer and the Claim Administrator.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

Should you wish to change from Family to Individual Coverage, you may do this at any time. Your Group Administrator will provide you with the application and tell you the date that the change will be effective.

TERMINATION OF COVERAGE

You will no longer be entitled to the benefits described in this benefit booklet if either of the events stated below should occur.

1. If you no longer meet the previously stated description of an Eligible Person.
2. If the entire coverage of your Employer terminates.
3. The date your severance package ends and COBRA rights start.

A person meets the criteria of (1) and (2) above while he is on a paid or unpaid leave of absence, for up to six months. Such extension of coverage, shall not count against any applicable COBRA continuation coverage. Further, termination of the agreement between the Claim Administrator and the Employer automatically terminates your coverage as described in this benefit booklet. It is the responsibility of the Employer to notify you in the event the agreement is terminated with the Claim Administrator. Regardless of whether such notice is provided, your coverage will terminate as of the effective date of termination of the Employer's agreement with the Claim Administrator.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under the Health Care Plan described in this benefit booklet except as otherwise specifically stated in the "Extension of Benefits in Case of Termination" provisions of this benefit booklet. However, termination of the Employer agreement with the Claim Administrator and/or termination of your coverage under the Health Care Plan shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this benefit booklet, if one of your dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible.

Other options available for Continuation of Coverage are explained in the COBRA Section of this benefit booklet.

Upon termination of your coverage under the Health Care Plan, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of

Creditable Coverage within 24 months of termination of your or your dependent's coverage under the Health Care Plan.

UTILIZATION REVIEW PROGRAM

The Claim Administrator has established the Utilization Review Program to assist you in determining the course of treatment that will maximize your benefits under this Health Care Plan. The Utilization Review Program requires a review of the following Covered Services **before** such services are rendered:

- Inpatient Hospital services
- Skilled Nursing Facility services
- Services received in a Coordinated Home Care Program
- Private Duty Nursing Services

You are responsible for satisfying Preadmission/Admission Review requirements. This means that you must ensure that you, your family member, or Provider of services must comply with the guidelines below. Failure to obtain Preadmission/Admission Review for services will require additional steps and/or benefit reductions as described in the provision entitled FAILURE TO NOTIFY. The toll-free telephone number for Preadmission/Admission Review is on your ID card. Please read the provisions below very carefully.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever a nonemergency or nonmaternity Inpatient Hospital admission is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the Hospital admission.

If the proposed Hospital admission or health care services are determined to be not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised verbally of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. These letters may not be received prior to your scheduled date of admission.

- **Emergency Admission Review**

Emergency admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

In the event of an emergency admission, in order to receive maximum benefits under this benefit booklet, you or someone who calls on your

behalf must notify the Claim Administrator no later than two business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

- **Pregnancy/Maternity Admission Review**

Pregnancy/Maternity admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Health Care Plan.

In the event of a maternity admission, in order to receive maximum benefits under this benefit booklet, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

Even though you are not required to call the Claim Administrator prior to your maternity admission, if you call the medical pre-notification number as soon as you find out you are pregnant, the Claim Administrator will provide you information on support programs to assist you during pregnancy.

- **Skilled Nursing Facility Preadmission Review**

Skilled Nursing Facility preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever an admission to a Skilled Nursing Facility is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

- **Coordinated Home Care Program Preadmission Review**

Coordinated Home Care Program preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever an admission to a Coordinated Home Care Program is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

- **Private Duty Nursing Service Review**

Private Duty Nursing Service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever Private Duty Nursing Service is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to receiving services.

CASE MANAGEMENT

Case management is a collaborative process that assists you with the coordination of complex care services. A Claim Administrator case manager is available to you as an advocate for cost-effective interventions.

Case managers are also available to you to provide assistance when you need alternative benefits. Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost-effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Health Care Plan.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Upon completion of the preadmission or emergency review, the Claim Administrator will send a letter to your Physician and/or the Hospital confirming that you or your representative called the Claim Administrator and that an approved length of service or length of stay was assigned.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. In the event that the extension is determined not to be Medically Necessary, the authorization will not be extended. Additional notification will be provided to your Physician and/or the Hospital regarding the denial of payment for the extension.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the Claim Administrator. The Claim Administrator will provide notification of a decision to not authorize

payment for Inpatient care or other health care services or supplies to you, your Physician, and/or the Hospital or other Provider. The notification will specify the dates, services and/or supplies that are not considered Covered Services. For further details regarding Medically Necessary care and other exclusions from coverage, see the EXCLUSIONS—WHAT IS NOT COVERED section in this benefit booklet.

The Claim Administrator does not determine your course of treatment or whether you receive particular health care services. Decisions regarding the course of treatment and receipt of particular health care services are a matter entirely between you and your Physician. The Claim Administrator's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is a Covered Service under the Health Care Plan.

In the event that the Claim Administrator determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service charge incurred.

Remember that the Claim Administrator's Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not determined to be Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as medically necessary, the Claim Administrator will not pay for the hospitalization, services or supplies unless the Claim Administrator determines it to be Medically Necessary and a Covered Service under the Health Care Plan.

NOTE: Keep in mind that a Medically Necessary determination does not guarantee that benefits are available. For example, it might be determined that a service is Medically Necessary, however, the Health Care Plan may limit or exclude that service. In that case, the Medically Necessary determination does not override the benefit provision in the benefit booklet.

UTILIZATION REVIEW PROCEDURE

The following information is required when you contact the Claim Administrator:

1. The name of the attending and/or admitting Physician;
2. The name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;
3. The scheduled admission and/or service date; and
4. A preliminary diagnosis or reason for the admission and/or service.

Upon receipt of the required information, the Claim Administrator:

1. will review the information provided and seek additional information as necessary.
2. will issue a determination that the services are either Medically Necessary or are not Medically Necessary.
3. will provide notification of the determination.

APPEAL PROCEDURE

If you or your Physician disagree with the determination of the Claim Administrator prior to or while receiving services, you may appeal that decision. You should call the Claim Administrator's customer service number on your identification card. Your Physician should use the contact information in the notification letter.

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Medical Director
Health Care Service Corporation
P. O. Box A3957
Chicago, Illinois 60601

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Claim Administrator will not interfere with your relationship with any Provider. However, the Claim Administrator has established the Utilization Review Program for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits provided under this benefit booklet.

Should you fail to notify the Claim Administrator as required in the Preadmission Review provision of this section, you will then be responsible for the first \$500 of the Hospital or facility charges for an eligible stay or \$500 of the charges for eligible Covered Services for Private Duty Nursing in addition to any deductibles, Copayments and/or Coinsurance applicable to this benefit booklet. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this benefit booklet nor can it be applied to your out-of-pocket expense limit, if applicable, as described in this benefit booklet.

MEDICARE ELIGIBLE MEMBERS

The preadmission review provisions of this Utilization Review Program do not apply to you if you are Medicare eligible and have secondary coverage provided under the Health Care Plan.

CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT

The Claim Administrator's Mental Health Unit has been established to perform preadmission review and length of stay review for your Inpatient Hospital services for the treatment of Mental Illness and Substance Use Disorder. The Mental Health Unit is staffed primarily by Physicians, Psychologists, and registered nurses.

Failure to contact the Mental Health Unit or to comply with the determinations of the Mental Health Unit may result in a reduction of benefits. The Mental Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Behavioral Health Practitioner or Provider of services must comply with the guidelines below. Failure to Preauthorize services will require additional steps and/or benefit reductions as described in the provision entitled FAILURE TO PREAUTHORIZE OR NOTIFY.

PREAUTHORIZATION REVIEW

- **Inpatient Hospital Preauthorization Review**

Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

In order to receive maximum benefits under this Health Care Plan, you must Preauthorize your nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Use Disorder by calling the Mental Health Unit. Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the Inpatient Hospital admission.

- **Emergency Mental Illness or Substance Use Disorder Admission Review**

Emergency Mental Illness or Substance Use Disorder Admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

In order to receive maximum benefits under this Health Care Plan, you or someone who calls on your behalf must notify the Mental Health Unit no later than two business days or as soon as reasonably possible after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits. Participating and Non-Participating Providers may Preauthorize services for you, when re-

quired, but it is your responsibility to ensure Preauthorization requirements are satisfied.

- **Partial Hospitalization Treatment Program Review**

Partial Hospitalization Treatment Program review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

In order to receive maximum benefits under this Health Care Plan, you must notify the Mental Health Unit no later than 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. Participating and Non-Participating Providers may call for you, when required, but it is your responsibility to ensure these requirements are satisfied. This call must be made at least 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. The Mental Health Unit will obtain information regarding the service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

If an Inpatient Emergency Mental Illness or Substance Use Disorder Admission occurs after a service(s), in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Mental Health Unit for an Emergency Mental Illness or Substance Use Disorder Admission Review.

- **Length of Stay/Service Review**

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Upon completion of the Preauthorization or Emergency Mental Illness or Substance Use Disorder Review, the Mental Health Unit will send you a letter confirming that you or your representative called the Mental Health Unit. A letter assigning a length of service or length of stay will be sent to your Behavioral Health Practitioner and/or the Hospital.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by the Mental Health Unit. In the event that the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to a Mental Health Unit Physician for review.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient Hospital admission or other health care services or supplies are not Medically Necessary, as such term is defined in this benefit booklet, will be determined by the Mental Health Unit. If the Mental Health Unit Physician concurs that the Inpatient Hospital admission, Outpatient service, or other health care service or supply does not meet the criteria for

Medically Necessary care, some days, services or the entire hospitalization will be denied. Your Behavioral Health Practitioner and in the case of an Inpatient Hospital admissions, the Hospital will be advised by telephone of this determinations, with a follow-up notification letter sent to you, your Behavioral Health Practitioner and the Hospital, and will specify the dates, services or supplies that are not considered Medically Necessary. The Mental Health Unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission or service. For further details regarding Medically Necessary care and other exclusions described in this benefit booklet, see the provision entitled, "EXCLUSIONS—WHAT IS NOT COVERED."

The Mental Health Unit does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Behavioral Health Practitioner. The Mental Health Unit's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is Medically Necessary under the Health Care Plan.

In the event that the Mental Health Unit determines that all or any portion of an Inpatient Hospital admission or other health care service or supply is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service or supply charge incurred.

Remember that your Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Behavioral Health Practitioner or another health care Provider may prescribe, order, recommend or approve an Inpatient Hospital admission or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Behavioral Health Practitioner prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the Mental Health Unit Physician decides they were not Medically Necessary.

MENTAL HEALTH UNIT PROCEDURE

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review you should be prepared to provide the following information:

1. the name of the attending and/or admitting Behavioral Health Practitioner;
2. the name of the Hospital or facility where the admission and/or service has been scheduled, when applicable;
3. the scheduled admission and/or service date; and

4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission and /or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review, the Mental Health Unit:

1. will review the medical information provided and follow-up with the Behavioral Health Practitioner;
2. upon request, will advise you of Participating Providers in the area who may be able to provide the admission and/or services that are the subject of the Preauthorization Review;
3. may determine that the admission and/or services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

Expedited Appeal

If you or your Behavioral Health Practitioner disagrees with the determinations of the Mental Health Unit prior to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Mental Health Unit and requesting an expedited appeal. The Mental Health Unit Physician will review your case and determine whether the service was Medically Necessary. You and/or your Behavioral Health Practitioner will be notified of the Mental Health Unit Physician's determination within twenty-four (24) hours or no later than the last authorized day. If you or your Behavioral Health Practitioner still disagree with the Mental Health Unit Physician, you may request an appeal in writing as outlined below.

Written Appeal

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after Claim processing has taken place or upon receipt of the notification letter from the Mental Health Unit, you may appeal that decision by having your Behavioral Health Practitioner call the contact person indicated in the notification letter or by submitting a written request to:

Blue Cross and Blue Shield of Illinois
Appeals Coordinator
Blue Cross and Blue Shield BH Unit
P. O. Box 660240
Dallas, Texas 75266-0240
Fax Number: 1-877-361-7656

You must exercise the right to this appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to the Claim Administrator as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may review any relevant documents held by the Claim Administrator, if you request an appointment in writing.

Within 30 days of receiving your request for review, the Claim Administrator will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO PREAUTHORIZE OR NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Mental Health Unit will not interfere with your relationship with any Behavioral Health Practitioner. However, the Mental Health Unit has been established for the specific purpose of assisting you in maximizing your benefits as described in this benefit booklet.

Should you fail to Preauthorize or notify the Mental Health Unit as required in the Preauthorization Review provision of this section, you will then be responsible for the first \$500 of the Hospital charges for an eligible Hospital stay in addition to any deductibles, Copayments and/or Coinsurance applicable to this benefit booklet. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this benefit booklet nor can it be applied to your out-of-pocket expense limit, if applicable to this benefit booklet.

INDIVIDUAL BENEFITS MANAGEMENT PROGRAM ("IBMP")

In addition to the benefits described in this benefit booklet, if your condition would otherwise require continued care in a Hospital or other health care facility, provision of alternative benefits for services rendered by a Participating Provider in accordance with an alternative treatment plan may be available to you.

Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations or exclusions of the Health Care Plan.

MEDICARE ELIGIBLE MEMBERS

The provisions of the CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT section do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Health Care Plan.

THE PARTICIPATING PROVIDER OPTION

Your Employer has chosen the Claim Administrator's "Participating Provider Option" for the administration of your Hospital and Physician benefits. The Participating Provider Option is a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

As a participant in the Participating Provider Option a directory of Participating Providers is available to you. You can visit the Blue Cross and Blue Shield of Illinois Web site at www.bcbsil.com for a list of Participating Providers. While there may be changes in the directory from time to time, selection of Participating Providers by the Claim Administrator will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided to your Employer annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Participating Provider.

Before reading the description of your benefits, you should understand the terms "Benefit Period" and "Deductible" as defined below.

YOUR BENEFIT PERIOD

Your benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first December 31st following that date.

YOUR DEDUCTIBLE

Each benefit period you must satisfy a \$500 deductible for Covered Services rendered by Participating Provider(s) and a separate \$2,000 deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Administrator Provider(s). In other words, after you have claims for Covered Services for more than the deductible amount in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.

FAMILY DEDUCTIBLE

If you have Family Coverage and your family has reached the program deductible amount of \$1,500 for Covered Services rendered by Participating Provider(s) and a separate \$4,500 program deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Administrator Provider(s), it will not be necessary for anyone else in your family to meet the program deductible in that benefit period. That is, for the remainder of that benefit period only, no other family member(s) is required to meet the program deductible before receiving benefits. A family member may not apply more than the individual program deductible amount toward the family program deductible.

In any case, should two or more members of your family ever receive Covered Services as a result of injuries received in the same accident, only one program deductible will be applied against those Covered Services.

HOSPITAL BENEFIT SECTION

Expenses for Hospital care are usually the biggest of all health care costs. Your Hospital benefits will help ease the financial burden of these expensive services. This section of your benefit booklet tells you what Hospital services are covered and how much will be paid for each of these services.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

The level of benefits paid for Hospital Covered Services is generally greater when received in an Administrator Hospital or other Administrator facility.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

INPATIENT CARE

The following are Covered Services when you receive them as an Inpatient in a Hospital.

Inpatient Covered Services

1. Bed, board and general nursing care when you are in:
 - a semi-private room
 - a private room
 - an intensive care unit
2. Ancillary services (such as operating rooms, drugs, surgical dressings and lab work)

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery.

These tests are considered part of your Inpatient Hospital surgical stay.

Partial Hospitalization Treatment

Benefits are available for this program only if it is an Administrator Program. No benefits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by the Claim Administrator.

Coordinated Home Care

Benefits will be provided for services under a Coordinated Home Care Program.

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES**Participating Provider**

When you receive Inpatient Covered Services from a Participating Provider or in an Administrator Program of a Participating Provider, benefits will be provided at 80% of the Eligible Charge after you have met your program deductible, unless otherwise specified in this benefit booklet. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Participating Provider

When you receive Inpatient Covered Services from a Non-Participating Provider or in an Administrator Program of a Non-Participating Provider, benefits will be provided at 70% of the Eligible Charge, after you have met your program deductible. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Administrator Provider

When you receive Inpatient Covered Services from a Non-Administrator Provider, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible.

Benefits for an Inpatient Hospital admission to a Non-Administrator or Non-Participating Provider resulting from Emergency Accident Care or Emergency Medical Care will be provided at the same payment level which you would have received had you been in a Participating Hospital for that portion of your Inpatient Hospital stay during which your condition is reasonably determined by the Claim Administrator to be serious and therefore not permitting your safe transfer to a Participating Hospital or other Participating Provider.

Benefits for an Inpatient Hospital admission to a Non-Administrator or Non-Participating Hospital resulting from Emergency Accident Care or Emergency Medical Care will be provided at the Non-Participating Hospital payment level or the Non-Administrator Hospital payment level (depending on the type of Provider) for that portion of your Inpatient Hospital stay during which your condition is reasonably determined by the Claim Administrator as not being serious and therefore permitting your safe transfer to a Participating Hospital or other Participating Provider.

In order for you to continue to receive benefits at the Participating Provider payment level following an emergency admission to a Non-Administrator or Non-Participating Hospital, you must transfer to a Participating Provider as soon as your condition is no longer serious.

OUTPATIENT HOSPITAL CARE

The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services

1. Surgery and any related Diagnostic Service received on the same day as the Surgery
2. Radiation Therapy Treatments
3. Chemotherapy
4. Electroconvulsive Therapy
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care
7. Urgent Care
8. Emergency Accident Care
9. Emergency Medical Care
10. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

Participating Provider

Benefits will be provided at 80% of the Eligible Charge after you have met your program deductible when you receive Outpatient Hospital Covered Services from a Participating Provider.

Benefits for urgent care from a Participating Provider will be provided at 100% of the Hospital's Eligible Charge, subject to a Copayment of \$40 per visit.

Non-Participating Provider

When you receive Outpatient Hospital Covered Services from a Non-Participating Provider, benefits will be provided at 70% of the Eligible Charge after you have met your program deductible.

Non-Administrator Provider

When you receive Outpatient Hospital Covered Services from a Non-Administrator Provider, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible. Covered Services received for Emergency Accident Care and Emergency Medical Care from a Non-Administrator

Provider will be paid at the same payment level which would have been paid had such services been received from a Participating Provider.

Emergency Care

Benefits for Emergency Accident Care will be provided at 100% of the Eligible Charge when you receive Covered Services from either a Participating, Non-Participating or Non-Administrator Provider. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the Emergency Accident Care payment level. Such services will be provided at the benefit payment level for Surgery described in this benefit booklet.

Benefits for Non-PPO emergency room physicians will be provided at the PPO benefit level if Covered Services for Emergency Accident Care are rendered in a PPO facility.

Benefits for Emergency Accident Care will not be subject to the program deductible.

Benefits for Emergency Medical Care will be provided at 100% of the Eligible Charge when you receive Covered Services from either a Participating, Non-Participating or Non-Administrator Provider.

Benefits for Emergency Medical Care will not be subject to the program deductible.

Benefits for Non-PPO emergency room physicians will be provided at the PPO benefit level if Covered Services for Emergency Medical Care are rendered in a PPO facility.

Each time you receive Covered Services in an emergency room, you will be responsible for a Copayment of \$150. If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room Copayment will be waived.

However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge whether or not you have met your program deductible. The emergency room Copayment will not apply.

Notwithstanding anything in this benefit booklet to the contrary, the method used to determine the Maximum Allowance for Emergency care services will be equal to the greatest of the following three possible amounts:

1. the amount negotiated with Participating Providers for emergency care benefits furnished; or
2. the amount for the emergency care service calculated using the same method the Participating Providers generally uses to determine payments for Non-Participating Provider services but substituting the Participating cost sharing provisions for the Non-Participating Provider cost-sharing provisions; or
3. the amount that would be paid under Medicare for the emergency care service.

Each of these three amounts is calculated excluding any Non-Participating Provider Copayment or Coinsurance imposed with respect to the covered person.

**WHEN SERVICES ARE NOT AVAILABLE FROM
A PARTICIPATING PROVIDER (HOSPITAL)**

If you must receive Hospital Covered Services which the Claim Administrator has reasonably determined are unavailable from a Participating Provider, benefits for the Covered Services you receive from a Non-Participating Provider will be provided at the payment level described for a Participating Provider.

PHYSICIAN BENEFIT SECTION

This section of your benefit booklet tells you what services are covered and how much will be paid when you receive care from a Physician or other specified Professional Provider.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available under this Benefit Section, services must be Medically Necessary and you must receive such services on or after your Coverage Date.

Remember, whenever the term “you” or “your” is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Surgery

Benefits are available for Surgery performed by a Physician, Dentist or Podiatrist. However, for services performed by a Dentist or Podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under this Health Care Plan had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

1. surgical removal of complete bony impacted teeth;
2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

1. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon’s office or Ambulatory Surgical Facility.

In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.
3. Sterilization Procedures (even if they are elective).

Additional Surgical Opinion

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Claim Charge. Your program deductible will not apply to this benefit. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

Medical Care

Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital, a Skilled Nursing Facility, or Substance Use Disorder Treatment Facility or
2. you are a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program or
3. you visit your Physician's office or your Physician comes to your home.

Consultations

Your coverage includes benefits for consultations. The consultation must be requested by your Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who also renders Surgery or Maternity Service during the same admission.

Diabetes Self-Management Training and Education

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professionals with expertise in diabetes management. Benefits for such health

care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

Diagnostic Service—Benefits will be provided for those services related to covered Surgery or Medical Care.

Emergency Accident Care

Emergency Medical Care

Electroconvulsive Therapy

Allergy Injections and Allergy Testing

Chemotherapy

Occupational Therapy

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Occupational Therapy will be limited to a maximum of 60 visits per benefit period.

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Physical Therapy will be limited to a maximum of 60 visits per benefit period.

Acupuncture – Benefits will be provided for acupuncture when performed by a licensed Provider. Your benefits for acupuncture and chiropractic and osteopathic manipulation will be limited to a combined maximum of 35 visits per benefit period.

Chiropractic and Osteopathic Manipulation—Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Your benefits for chiropractic and

osteopathic manipulation will be limited to a maximum of 35 visits per benefit period.

Radiation Therapy Treatments

Speech Therapy

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. Outpatient Speech Therapy benefits will be limited to a maximum of 60 visits per benefit period.

Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician.

Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Durable Medical Equipment—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates and any other internal and permanent devices. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

Amino Acid-Based Elemental Formulas—Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is medically necessary. If you purchase the formula at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet.

Orthotic Devices

Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary. However, benefits will not be provided for foot orthotics defined as any in-shoe device designed to support the structural components of the foot during weight-bearing activities.

Outpatient Contraceptive Services

Benefits will be provided for prescription contraceptive devices, injections, implants and Outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

Benefits for prescription contraceptive devices and implants will not be subject to a calendar year maximum.

Prosthetic Appliances

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

1. they are required to replace all or part of an organ or tissue of the human body, or
2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required).

Routine Pediatric Hearing Examination—Benefits will be provided for routine pediatric hearing examinations.

Pulmonary Rehabilitation Therapy—Benefits will be provided for outpatient cardiac/pulmonary rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services.

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

The benefits provided by the Claim Administrator and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Professional Provider.

Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist, benefits will be provided at 80% of the Maximum Allowance after you have met your program deductible, unless otherwise specified in this benefit booklet. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this benefit booklet and may bill you for

the difference between the Claim Administrator's benefit payment and the Provider's charge to you.

When you receive Covered Services (except for those services specified below) in a Participating Provider's office (other than a specialist's office), benefits for Covered Services, including all related Covered Services received on the same day, are subject to a Copayment of \$25 per visit. Benefits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

When you receive Covered Services (except for those services specified below) in a Participating Provider specialist's office, benefits for Covered Services, including all related Covered Services received on the same day, are subject to a Copayment of \$40 per visit. A specialist is a Professional Provider who is **not** a Behavioral Health Practitioner or a Physician in general practice, family practice, internal medicine, psychiatry, obstetrics, gynecology or pediatrics. Benefits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

The following Covered Services are not subject to the office visit Copayment, and benefits will be provided at the general medical/surgical payment level:

- Surgery
- Occupational Therapy
- Physical Therapy
- Speech Therapy

Non-Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Non-Participating Provider, benefits will be provided at 70% of the Maximum Allowance after you have met your program deductible.

Emergency Care

Benefits for Emergency Accident Care will be provided at 100% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider. Your program deductible will not apply. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the Emergency Accident Care payment level. Such services will be provided at the benefit payment level for Surgery described in this benefit booklet.

When you receive Covered Services for Emergency Accident Care in a Participating Provider's office (other than a specialist), benefits for office visits are subject to a Copayment of \$40 per visit. Benefits for office visits will be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

When you receive Covered Services for Emergency Accident Care in a Participating Provider specialist's office, benefits for Covered Services are subject to a Copayment of \$40 per visit. A specialist is a Professional Provider who is

not a Behavioral Health Practitioner or a Physician in general practice, family practice, internal medicine, psychiatry, obstetrics, gynecology or pediatrics. Benefits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

Benefits for Emergency Medical Care will be provided at 100% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider. Your program deductible will not apply.

When you receive Covered Services for Emergency Medical Care in a Provider's office (other than a specialist), benefits for office visits are subject to a Copayment of \$40 per visit. Benefits for office visits will be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

When you receive Covered Services for Emergency Medical Care in a Participating Provider specialist's office, benefits for Covered Services are subject to a Copayment of \$40 per visit. A specialist is a Professional Provider who is **not** a Behavioral Health Practitioner or a Physician in general practice, family practice, internal medicine, psychiatry, obstetrics, gynecology or pediatrics. Benefits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

However, Covered Services for Emergency Accident Care and Emergency Medical Care resulting from a criminal sexual assault or abuse will be paid at 100% of the Maximum Allowance whether or not you have met your program deductible. The office visit Copayment will not apply.

Notwithstanding anything in this benefit booklet to the contrary, the method used to determine the Maximum Allowance for Emergency care services will be equal to the greatest of the following three possible amounts:

1. the amount negotiated with Participating Providers for emergency care benefits furnished; or
2. the amount for the emergency care service calculated using the same method the Participating Providers generally uses to determine payments for Non-Participating Provider services but substituting the Participating cost sharing provisions for the Non-Participating Provider cost-sharing provisions; or
3. the amount that would be paid under Medicare for the emergency care service.

Each of these three amounts is calculated excluding any Non-Participating Provider Copayment or Coinsurance imposed with respect to the covered person.

Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists

- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists

who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Social Workers

- Clinical Professional Counselors
- Clinical Laboratories
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists
- other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider or the Claim Administrator.

OTHER COVERED SERVICES

OTHER COVERED SERVICES

This section of your benefit booklet describes “Other Covered Services” and the benefits that will be provided for them.

- The processing, transporting, storing, handling and administration of blood and blood components.
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Your benefits for Private Duty Nursing Service are limited to a maximum of 60 visits per benefit period.
- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- Oxygen and its administration
- Medical and surgical dressings, supplies, casts and splints
- Naprapathic Service — Benefits will be provided for Naprapathic Services when rendered by a Naprapath.
- Hearing Aids—Benefits will be provided for hearing aids for children limited to two every 36 months.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

After you have met your program deductible, benefits will be provided at 70% of the Eligible Charge or 70% of the Maximum Allowance for any of the Covered Services described in this section.

When you receive Other Covered Services from a Participating or Non-Participating Provider, benefits for Other Covered Services will be provided at the payment levels previously described in this benefit booklet for Hospital and Physician Covered Services.

Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Physical Therapists
- Retail Health Clinics
- Speech Therapists

who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists

- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Physical Therapists
- Retail Health Clinics
- Speech Therapists
- other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider or the Claim Administrator.

SPECIAL CONDITIONS AND PAYMENTS

There are some special things that you should know about your benefits should you receive any of the following types of treatments:

HUMAN ORGAN TRANSPLANTS

Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have coverage each will have their benefits paid by their own program.
- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in this benefit booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.
- If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this benefit booklet will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant Surgery.
- the evaluation, preparation and delivery of the donor organ.
- the removal of the organ from the donor.
- the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:

- **Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact the Claim Administrator by telephone before your transplant Surgery has been scheduled. The Claim Administrator will furnish you with the names of Hospitals which have Claim Administrator approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any Hospital that does not have a Claim Administrator approved Human Organ Transplant Program.**

- If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this benefit booklet, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.
- You and your companion are each entitled to benefits for lodging up to a maximum of \$50 per day.
- In addition to the other exclusions of this benefit booklet, benefits will not be provided for the following:
 - Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
 - Travel time and related expenses required by a Provider.
 - Drugs which do not have approval of the Food and Drug Administration.
 - Storage fees.
 - Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.
 - Meals.

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Claim Administrator approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization.

PREVENTIVE CARE SERVICES

Benefits will be provided for the following Covered Services and will not be subject to any deductible, Coinsurance, Copayment or maximum when such services are received from a Participating Provider:

- evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);
- immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;
- evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and

Services Administration ("HRSA") for infants, children, and adolescents;

- with respect to women, such additional preventive care and screenings, not described above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The preventive care services described above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the website at www.bcbsil.com or contact customer service at the toll-free number on your identification card.

Examples of covered services included are routine annual physicals, immunizations, well child(ren) care, cancer screenings, mammograms, bone density tests, screenings for prostate cancer and colorectal cancer, smoking cessation services and healthy diet counseling and obesity screenings/counseling.

Examples of covered immunizations included are Diphtheria, Haemophilus influenza type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, rubella, Tetanus, Varicella and other immunization that is required by law for a child(ren). Allergy injections are not considered immunizations under this benefit provision.

Preventive services received from a Non-Participating Provider or other routine Covered Services not provided for under this provision will be subject to the deductible, Coinsurance, Copayments and/or benefit maximum as described under the provisions of this benefit booklet.

WELLNESS CARE

Benefits will be provided for Covered Services rendered to you, even though you are not ill. Benefits will be limited to the following services:

- Routine diagnostic medical procedures;
- Routine EKG;
- Routine x-ray;
- Routine ovarian cancer screening;
- Routine colorectal cancer screening x-ray.

Participating Provider

When you receive Covered Services for wellness care from a Participating Provider, benefits for wellness care will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance and will not be subject to the program deductible.

Non-Participating Provider

When you receive Covered Services for wellness care from a Non-Participating Provider, benefits will be provided at 70% of the Eligible Charge or 70% of the Maximum Allowance after you have met your program deductible.

SKILLED NURSING FACILITY CARE

The following are Covered Services when you receive them in a Skilled Nursing Facility:

1. Bed, board and general nursing care.
2. Ancillary services (such as drugs and surgical dressings or supplies).

No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.

Benefits for Covered Services rendered in an Administrator Skilled Nursing Facility will be provided at 80% of the Eligible Charge after you have met your program deductible.

Benefits for Covered Services rendered in a Non-Administrator Skilled Nursing Facility will be provided at 50% of the Eligible Charge, once you have met your program deductible. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.

AMBULATORY SURGICAL FACILITY

Benefits for all of the Covered Services previously described in this benefit booklet are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

Benefits for services rendered by an Administrator Ambulatory Surgical Facility will be provided at 80% of the Eligible Charge. Benefits for services rendered by a Non-Administrator Ambulatory Surgical Facility will be provided at 50% of the Eligible Charge.

Benefits for Outpatient Surgery will be provided as stated above after you have met your program deductible.

AUTISM SPECTRUM DISORDER(S)

Your benefits for the diagnosis and treatment of Autism Spectrum Disorder(s) are the same as your benefits for any other condition. Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder (a) by a Physician or a Psychologist who has determined that such care is medically necessary, or (b) by a certified, registered or licensed health care professional with expertise in treating Autism Spectrum Disorder(s) and when such care is determined to be medically necessary and ordered by a Physician or a Psychologist:

- psychiatric care, including diagnostic services;

- psychological assessments and treatments;
- habilitative or rehabilitative treatments;
- therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in the following areas: a) self care and feeding, b) pragmatic, receptive and expressive language, c) cognitive functioning, d) applied behavior analysis (ABA), intervention and modification, e) motor planning and f) sensory processing.

HABILITATIVE SERVICES

Your benefits for Habilitative Services with Congenital, Genetic, or Early Acquired Disorder are the same as your benefits for any other condition if all of the following conditions are met:

- a physician has diagnosed the Congenital, Genetic, or Early Acquired Disorder; and
- treatment is administered by a licensed speech-language pathologist, audiologist, Occupational Therapist, Physical Therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, or Psychologist upon the referral of a Physician; and
- treatment must be Medically Necessary and therapeutic and not Investigational.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT

Benefits for all of the Covered Services described in this benefit booklet are available for Substance Use Disorder Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Use Disorder Treatment Facility. Inpatient benefits for these Covered Services will also be provided for Substance Use Disorder Rehabilitation Treatment in a Residential Treatment Center. Substance Use Disorder Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with the Claim Administrator or in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.

DETOXIFICATION

Covered Services received for detoxification are not subject to the Substance Use Disorder treatment provisions specified above. Benefits for Covered Services received for detoxification will be provided under the HOSPITAL BENEFITS and PHYSICIAN BENEFITS section of this benefit booklet, the same as for any other condition.

MENTAL ILLNESS AND SUBSTANCE USE DISORDER SERVICES

Benefits for all of the Covered Services described in this benefit booklet are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder. Treatment of a Mental Illness or Substance Use Disorder

is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license. Covered Services rendered in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.

BARIATRIC SURGERY

Benefits for Covered Services received for bariatric Surgery will be provided under the HOSPITAL BENEFIT and PHYSICIAN BENEFIT sections of this benefit booklet, the same as for any other condition.

MATERNITY SERVICE

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one routine Inpatient examination and c) one Inpatient hearing screening as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth).

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from the Claim Administrator for prescribing a length of stay less than 48 hours (or 96 hours).

Your coverage also includes benefits for elective abortions if legal where performed.

INFERTILITY TREATMENT

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis and/or treatment of infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection.

Infertility means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. The one year requirement will be waived if your Physician determines a medical condition exists that makes conception impossible through unprotected sexual

intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to Chemotherapy or radiation treatments; or, efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

Unprotected sexual intercourse means sexual union between a male and female without the use of any process, device or method that prevents conception including, but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

Benefits for treatments that include oocyte retrievals will be provided only when:

- You have been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that makes such treatment useless; and
- You have not undergone four completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals shall be covered.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure to transfer the oocytes or sperm to you. Associated donor medical expenses are also covered, including, but not limited to, physical examinations, laboratory screenings, psychological screenings and prescription drugs.

The maximum number of completed oocyte retrievals that are eligible for coverage under this benefit booklet in your lifetime is six. If an oocyte donor is used, then the completed oocyte retrieval performed on the donor shall count as one completed oocyte retrieval. Following the final completed oocyte retrieval, benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to you. Thereafter, you will have no benefits for infertility treatment.

Special Limitations

Benefits will not be provided for the following:

1. Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from you will be covered if you choose to use a surrogate.
2. Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term.
3. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.

4. Non-medical costs of an egg or sperm donor.
5. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary or required by the Claim Administrator.
6. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.
7. Infertility treatment rendered to your dependents under age 18.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

Benefits for all of the Covered Services previously described in this benefit booklet are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

MASTECTOMY-RELATED SERVICES

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are not limited to:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Inpatient care following a mastectomy for the length of time determined by your attending Physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within 48 hours after discharge; and
4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.
5. The removal of breast implants when the removal of the implants is a Medically Necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury is not considered cosmetic surgery.

PAYMENT PROVISIONS

Lifetime Maximum

Your benefits are not subject to a lifetime maximum. The total dollar amount that will be available in benefits for you is unlimited.

OUT-OF-POCKET EXPENSE LIMIT

There are separate Out-of-Pocket Expense Limits applicable to Covered Services received from Participating Providers and Non-Participating Providers.

For Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals \$1,500, any additional eligible Claims for Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Participating or Non-Administrator Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Participating Provider or a Non-Administrator Provider
- Copayments resulting from noncompliance with the provisions of the UTILIZATION REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT
- charges for Outpatient prescription drugs
- and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed.

If you have Family Coverage and your out-of-pocket expense as described above equals \$4,500 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

If you have Family Coverage, each member of your family must satisfy the out-of-pocket expense limit.

For Non-Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals \$4,500, any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the Non-Participating Provider program deductible
- the payments for Covered Services rendered by a Non-Participating Provider for which you are responsible after benefits have been provided

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Administrator Hospital or other Non-Administrator Provider facility
- charges for Outpatient prescription drugs
- the Hospital emergency room Copayment
- Copayments resulting from noncompliance with the provisions of the UTILIZATION REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT
- any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period.

If you have Family Coverage and your expense as described above equals \$13,500 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

If you have Family Coverage, each member of your family must satisfy the out-of-pocket expense limit.

HOSPICE CARE PROGRAM

Your Hospital coverage also includes benefits for Hospice Care Program Service.

Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

1. Coordinated Home Care;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services – Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services;
10. Respite Care Service.

The following services are **not** covered under the Hospice Care Program:

1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
5. Transportation, including, but not limited to, Ambulance Transportation.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this benefit booklet.

Benefit Payment for Hospice Care Program Services

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same payment level as described for Inpatient Hospital Covered Services.

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION

When you are being treated for an illness or accident, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage includes benefits for drugs and supplies which are self-administered. This section of your benefit booklet explains which drugs and supplies are covered and the benefits that are available for them. Benefits will be provided only if such drugs and supplies are Medically Necessary.

Although you can go to the Pharmacy of your choice, your benefit for drugs and supplies will be greater when you purchase them from a Participating Prescription Drug Provider. You can visit the Claim Administrator's Web site at www.bcbsil.com for a list of Participating Prescription Drug Providers. The Pharmacies that are Participating Prescription Drug providers may change from time to time. You should check with your Pharmacy before purchasing drugs or supplies to make certain of its participation status.

The benefits of this section are subject to all of the terms and conditions of this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For purposes of this Benefit Section only, the definition of Eligible Charge shall read as follows:

ELIGIBLE CHARGE.....means (a) in the case of a Provider which has a written agreement with the Claim Administrator or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program to provide Covered Services to you at the time you receive the Covered Services, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with a Blue Cross and Blue Shield Plan or the entity chosen by the Claim Administrator to provide services to you at the time you receive Covered Services, either of the following charges for Covered Services:

- (i) the charge which the particular Prescription Drug Provider usually charges for Covered Services, or
- (ii) the agreed upon cost between Participating Prescription Drug Providers and a Blue Cross and Blue Shield Plan or the entity chosen by the Claim Administrator to administer its prescription drug program, whichever is lower.

Additionally, the following definition(s) shall apply to this Benefit Section:

FORMULARY.....means a brand name drug or brand name diabetic supply that has been designated as a preferred drug or supply by the Claim Administrator.

SPECIALTY DRUGS.....means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected or infused, but may also include high cost oral medications. In addition, patient support and/or education may be required for these drugs.

The list of Specialty Drugs is subject to change. You should refer to the formulary list, contact your Pharmacy or refer to the Claim Administrator's Web site (www.bcbsil.com) to determine which drugs are Specialty Drugs.

COVERED SERVICES

The drugs and supplies for which benefits are available under this Benefit Section are:

- drugs which are self-administered that require, by federal law, a written prescription;
- self-injectable insulin and insulin syringes;
- diabetic supplies, as follows: test strips, glucagon emergency kits and lancets.

Benefits for these drugs will be provided when:

- you have been given a written prescription for them by your Physician, Dentist, Optometrist or Podiatrist and
- you purchase the drugs from a Pharmacy or from a Physician, Dentist, Optometrist or Podiatrist who regularly dispenses drugs, and
- the drugs are self-administered.

Benefits will not be provided for:

- drugs used for cosmetic purposes (including, but not limited to, Retin-A/ Tretinoin and Minoxidil/Rogaine);
- drugs which are not self-administered;
- any devices or appliances except as specifically mentioned above;
- any charges that you may incur for the drugs being administered to you.

In addition, benefits will not be provided for any refills if the prescription is more than one year old.

One prescription means up to a 34 consecutive day supply of a drug. Certain drugs may be limited to less than a 34 consecutive day supply. However, for certain maintenance type drugs, larger quantities may be obtained through the Home Delivery Prescription Drug Program. For information on these drugs, contact your Participating Prescription Drug Provider or the Claim Administrator's office. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

Out of Pocket

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals \$1,500, any additional eligible Claims for Participating Providers RPO Prescription Drugs or Participating Prescription Drug Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

If you have Family Coverage and your out-of-pocket expense as described above equals \$4,500 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

Benefit Payment for Prescription Drugs

The benefits you receive and the Copayment amount you pay will differ depending upon the type of drugs purchased and whether they are obtained from a Participating Prescription Drug Provider.

When you obtain drugs from a Participating Prescription Drug Provider, you must pay a Copayment amount of:

- **\$15 for each prescription** – for generic drugs.
- **\$40 for each prescription** – for Formulary brand name drugs.
- **\$60 for each prescription** – for non-Formulary brand name drugs.
- **\$60 for each prescription** – for self-injectable drugs other than insulin.

When you obtain diabetic supplies from a Participating Prescription Drug Provider, you must pay the Formulary brand name Copayment amount described above for each prescription. Benefits will be provided for the remaining Eligible Charge.

When you obtain drugs or diabetic supplies from a non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider), 75% of the Eligible Charge will be paid minus the Copayment amount.

Home Delivery Prescription Drug Program

In addition to the benefits described in this Benefit Section, your coverage includes benefits for maintenance type drugs and oral contraceptives obtained through the Home Delivery Prescription Drug Program. For information about this program, contact your employer or Claim Administrator.

When you obtain drugs through the Home Delivery Prescription Drug Program, you must pay a Copayment amount of:

- **\$25 for each prescription** – for generic drugs.
- **\$85 for each prescription** – for Formulary brand name drugs.
- **\$135 for each prescription** – for non-Formulary brand name drugs.
- **\$135 for each prescription** – for self-injectable drugs other than insulin and infertility drugs.

When you obtain diabetic supplies from a Participating Prescription Drug Provider, you must pay the Formulary brand name Copayment amount described above for each prescription. Benefits will be provided for the remaining Eligible Charge.

BENEFITS FOR MEDICARE ELIGIBLE COVERED PERSONS

This section describes the benefits which will be provided for Medicare Eligible Covered Persons who are not affected by MSP laws, unless otherwise specified in this benefit booklet (see provisions entitled “Medicare Eligible Covered Persons” in the ELIGIBILITY SECTION of this benefit booklet).

The benefits and provisions described throughout this benefit booklet apply to you, however, in determining the benefits to be paid for your Covered Services, consideration is given to the benefits available under Medicare.

The process used in determining benefits under the Health Care Plan is as follows:

1. determine what the payment for a Covered Service would be following the payment provisions of this coverage.
2. deduct from the charges eligible under Medicare, the amount paid by Medicare. (If you are eligible for Medicare, the amount that is available from Medicare will be deducted whether or not you have enrolled and/or received payment from Medicare.)
3. the lesser of the two amounts determined in accordance with step 1 and step 2 above is the amount that will be paid under the Health Care Plan.

When you have a Claim, you must send the Claim Administrator a copy of your Explanation of Medicare Benefits (“EOMB”) in order for your Claim to be processed. In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used.

EXCLUSIONS - WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

— **Hospitalization, services and supplies which are not Medically Necessary.**

No benefits will be provided for services which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of the Claim Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
- Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.

The Claim Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your health care plan. In most instances this decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's decision, your plan provides for an appeal of that decision.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, THE CLAIM ADMINISTRATOR WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY.

- Services or supplies that are not specifically mentioned in this benefit booklet.
- Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.
- Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

- Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.
- Services or supplies that do not meet accepted standards of medical and/or dental practice.
- Investigational Services and Supplies and all related services and supplies, except as may be provided under this benefit booklet for a) the cost of routine patient care associated with Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with a qualified cancer trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).
- Custodial Care Service.
- Long Term Care Service.
- Respite Care Service, except as specifically mentioned under the Hospice Care Program.
- Inpatient Private Duty Nursing Service.
- Routine physical examinations, unless otherwise specified in this benefit booklet.
- Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Charges for failure to keep a scheduled visit or charges for completion of a Claim form.
- Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this benefit booklet.
- Blood derivatives which are not classified as drugs in the official formularies.

- Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this benefit booklet.
- Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.
- Routine foot care, except for persons diagnosed with diabetes.
- Immunizations, unless otherwise specified in this benefit booklet.
- Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this benefit booklet.
- Maintenance Care.
- Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation, except as may be provided under this benefit booklet for Autism Spectrum Disorder(s).
- Habilitative Services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.
- Hearing aids or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this benefit booklet.
- Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this benefit booklet.
- Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
- Wigs (also referred to as cranial prostheses), unless otherwise specified in this benefit booklet.
- Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this benefit booklet.
- Reversals of sterilization.
- Gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery), including related services and supplies.
- Residential Treatment Centers, except for Inpatient Substance Use Disorders as specifically mentioned in this benefit booklet.

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies when you have health care coverage through more than one group program. The purpose of COB is to insure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claim Administrator of the existence of such other group coverages. COB does not apply to the Out-patient Prescription Drug Program Benefit Section.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

1. The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.
2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this "birthday" type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.
 - However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;
 - when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to

notify the Claim Administrator, and upon its request to provide a copy, of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

The Claim Administrator has the right in administering these COB provisions to:

- pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.
- recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person or other organization.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This CONTINUATION COVERAGE RIGHTS UNDER COBRA section does not apply to Domestic Partners and their children.

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE RIGHTS UNDER COBRA. See your employer or Group Administrator should you have any questions about COBRA.

Introduction

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;

- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administra-

tor for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period Of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension Of 18-Month Period Of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying

event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed Of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

CONTINUATION OF COVERAGE FOR DOMESTIC PARTNERS

The purpose of this section of your benefit booklet is to explain the options available for temporarily continuing your coverage after termination, if you are covered under this benefit booklet as the Domestic Partner of an Eligible Person or as the dependent child of a Domestic Partner. Your continued coverage under this benefit booklet will be provided only as specified below. Please read the provisions very carefully.

Continuation of Coverage

If you are the Domestic Partner or the dependent child of a Domestic Partner and you lose coverage under this benefit booklet, you have the same options as the spouse or dependent child of an Eligible Person to continue your coverage. The options available to a spouse or a dependent child are described in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable to your Group.

NOTE: Certain employers may not be required to offer COBRA continuation coverage. See your Group Administrator if you have any questions about COBRA.

In addition to the events listed in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Domestic Partnership with the Eligible Person terminates. Your Domestic Partnership will terminate if your partnership no longer meets the criteria described in the definition of “Domestic Partnership” in the DEFINITIONS SECTION of this benefit booklet. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

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**CLAIM FILING AND
APPEALS PROCEDURES**

In order to obtain your benefits under this benefit program, it is necessary for a Claim to be filed with the Claim Administrator. To file a Claim, usually all you will have to do is show your ID card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember however, it is your responsibility to ensure that the necessary Claim information has been provided to the Claim Administrator.

Once the Claim Administrator receives your Claim, it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how your benefits were calculated. In some cases the Claim Administrator will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from your Employee Benefits Department or from the Claim Administrator's office.
2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge.
3. Mail the completed Claim Form with attachments to:

Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, Illinois 60680-4112

In any case, Claims should be filed with the Claim Administrator on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished the succeeding calendar year.) **Claims not filed within the required time period will not be eligible for payment.**

Should you have any questions about filing Claims, ask your Employee Benefits Department or call the Claim Administrator's office.

FILING OUTPATIENT PRESCRIPTION DRUG CLAIMS

In certain situations, you will have to file your own Claims in order to obtain benefits for Outpatient prescription drugs. This is primarily true when you did not receive an identification card, the Pharmacy was unable to transmit a Claim or you received benefits from a non-Participating Prescription Drug Provider. To do so, follow these instructions:

1. Complete a prescription drug Claim Form. These forms are available from your Employee Benefits Department or from the Claim Administrator's office.
2. Attach copies of all Pharmacy receipts to be considered for benefits. These receipts must be itemized.
3. Mail the completed Claim Form with attachments to:

Blue Cross and Blue Shield of Illinois
P.O. Box 14624
Lexington, KY 40512-4624

In any case, Claims must be filed no later than one year after the date a service is received. Claims not filed within one year from the date a service is received will not be eligible for payment.

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIMS DETERMINATIONS

The Claim Administrator will usually pay all Claims within 30 days of receipt of all information required to process a Claim. The Claim Administrator will usually notify you, your valid assignee or your authorized representative, when all information required to pay a Claim within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provisions in the GENERAL PROVISIONS section of this benefit booklet.) If you fail to follow the procedures for filing a pre-service claim (as defined below), you will be notified within 5 days (or within 24 hours in the case of a failure regarding an urgent care/expedited clinical claim [as defined below]). Notification may be oral unless the claimant requests written notification.

If a Claim Is Denied or Not Paid in Full

If a claim for benefits is denied in whole or in part, you will receive a notice from the Claim Administrator within the following time limits:

1. For non-urgent pre-service claims, within 15 days after receipt of the claim by the Claim Administrator. A "pre-service claim" is any non-urgent request for benefits or for a determination, with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
2. For post-service Claims, within 30 days after receipt of the Claim by the Claim Administrator. A "post-service claim" is a Claim as defined above.

If the Claim Administrator determines that special circumstances require an extension of time for processing the claim, for non-urgent pre-service and post-service claims, the Claim Administrator shall notify you or your authorized representative in writing of the need for extension, the reason for the extension, and the expected date of decision within the initial period. In no event shall such extension exceed 15 days from the end of such initial period.

If an extension is necessary because additional information is needed from you, the notice of extension shall also specifically describe the missing information, and you shall have at least 45 days from receipt of the notice within which to provide the requested information.

If the claim for benefits is denied in whole or in part, you or your authorized representative shall be notified in writing of the following:

- a. The reasons for denial;
- b. A reference to the benefit plan provisions on which the denial is based;
- c. A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
- d. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), diagnosis, treatment and denial codes with their meanings and the standards used;
- e. An explanation of the Claim Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;
- f. In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other benefit information may be available in such non-English language(s);
- g. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- h. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- i. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- j. In the case of a denial of an urgent care/expedited clinical claim, a description of the expedited review procedure applicable to such claims. An urgent care/expedited claim decision may be provided orally, so long as written notice is furnished to the claimant within 3 days of oral notification;
- k. Contact information for applicable office of health insurance consumer assistance or ombudsman.

3. For benefit determinations relating to urgent care/expedited clinical claim (as defined below), such notice will be provided no later than 24 hours after the receipt of your claim for benefits, unless you fail to provide sufficient information. You will be notified of the missing information and will have no less than 48 hours to provide the information. A benefit determination will be made within 48 hours after the missing information is received.
4. For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your claim for benefits.

An “urgent care/expedited clinical claim” is any pre-service claim for benefits for medical care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

INQUIRIES AND COMPLAINTS

An “**Inquiry**” is a general request for information regarding claims, benefits, or membership.

A “**Complaint**” is an expression of dissatisfaction by you either orally or in writing.

The Claim Administrator has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to, the following:

- Claims
- Quality of care

When your Complaint relates to dissatisfaction with a claim denial (or partial denial), then you have the right to a claim review/appeal as described in the CLAIM APPEAL PROCEDURES.

To pursue an Inquiry or a Complaint, you may contact **Customer Service** at the number on the back of your ID card, or you may write to:

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, Illinois 60601

When you contact Customer Service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of receipt by Customer Service. Sometimes the acknowledgement and the response will be combined. If the Claim Administrator needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information, you will be contacted.

An appeal is an oral or written request for review of an Adverse Benefit Determination (as defined below) or an adverse action by the Claim Administrator, its employees or a participating provider.

CLAIM APPEAL PROCEDURES - DEFINITIONS

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your ID card.

An **“Adverse Benefit Determination”** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator or your Employer and the Claim Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination of the Employer’s benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

In addition, an Adverse Benefit Determination, also includes an “Adverse Determination.” An **“Adverse Determination”** means a determination by the Claim Administrator or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a Covered Service has been reviewed and, based upon the information provided, does not meet the Claim Administrator’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. For purposes of this benefit program, we will refer to both an Adverse Determination and an Adverse Benefit Determination as an Adverse Benefit Determination, unless indicated otherwise.

A **“Final Internal Adverse Benefit Determination”** means an Adverse Benefit Determination that has been upheld by the Claim Administrator or your Employer at the completion of the Claim Administrator’s or Employer’s internal review/appeal process.

CLAIM APPEAL PROCEDURES

If you have received an Adverse Benefit Determination, you may have your Claim reviewed on appeal. The Claim Administrator will review its decision in accordance with the following procedures. The following review procedures will also be used for Claim Administrator’s (i) coverage determinations

that are related to non-urgent care that you have not yet received if approval by your plan is a condition of your opportunity to maximize your benefits and (ii) coverage determinations that are related to care that you are receiving at the same time as the determination. Claim reviews are commonly referred to as “appeals.”

Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the Claim Administrator to request a claim review. The Claim Administrator will need to know the reasons why you do not agree with the Adverse Benefit Determination. You may call 1-877-284-9302 or send your request to:

Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690

In support of your Claim review, you have the option of presenting evidence and testimony to the Claim Administrator, by phone or in person at a location of the Claim Administrator’s choice. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the Claim review process.

The Claim Administrator will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of your Claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale and information will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. The appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors, but who were not involved in making the initial denial of your Claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator or your Employer.

Urgent Care/Expedited Clinical Appeals

If your appeal relates to an urgent care/expedited clinical claim, or health care services, including but not limited to, procedures or treatments ordered by a health care provider, the denial of which could significantly increase the risk to the claimant’s health, then you may be entitled to an appeal on an expedited basis. Before authorization of benefits for an ongoing course of treatment is terminated or reduced, the Claim Administrator will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an urgent care/expedited pre-service or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Claim Administrator shall render a determination on the appeal within 24 hours after it receives the requested information.

Other Appeals

Upon receipt of a non-urgent pre-service or post-service appeal the Claim Administrator shall render a determination of the appeal within 30 days after the appeal has been received by the Claim Administrator or such other time as required or permitted by law.

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters at 1-800-538-8833. The Claim Administrator offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9431, or call the number on the back of your ID card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Notice of Appeal Determination

The Claim Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, orally of its determination followed-up by a written notice of the determination.

The written notice will include:

1. The reasons for the determination;
2. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), and information about how to obtain diagnosis, treatment and denial codes with their meanings;

4. An explanation of the Claim Administrator's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal;
5. In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other benefit information may be available in such non-English language(s);
6. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
7. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
8. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
9. A description of the standard that was used in denying the claim and a discussion of the decision.

If the Claim Administrator's or your Employer's decision is to continue to deny or partially deny your Claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the INDEPENDENT EXTERNAL REVIEW section below.

If an appeal is not resolved to your satisfaction, you may appeal the Claim Administrator's decision to the Illinois Department of Insurance. The Illinois Department of Insurance will notify the Claim Administrator of the appeal. The Claim Administrator will have 21 days to respond to the Illinois Department of Insurance.

Some of the operations of the Claim Administrator are regulated by the Illinois Department of Insurance. Filing an appeal does not prevent you from filing a Complaint with the Illinois Department of Insurance or keep the Illinois Department of Insurance from investigating a Complaint.

You must exercise the right to internal appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity. If you have an adverse appeal determination, you may file civil action in a state or federal court.

STANDARD EXTERNAL REVIEW

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO).

An “**Adverse Benefit Determination**” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator or your Employer and the Claim Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination of the Employer’s benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

A “**Final Internal Adverse Benefit Determination**” means an Adverse Benefit Determination that has been upheld by the Claim Administrator at the completion of the Claim Administrator’s internal review/appeal process.

1. **Request for external review.** Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review. If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
2. **Preliminary review.** Within 5 business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:
 - a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
 - b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
 - c. You have exhausted the Claim Administrator’s internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the **EXHAUSTION** section below for additional information and exhaustion of the internal appeal process; and
 - d. You or your authorized representative have provided all the information and forms required to process an external review.

You will be notified within 1 business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

- 3. Referral to Independent Review Organization.** When an eligible request for external review is completed within the time period allowed, Claim Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the Claim Administrator will take action against bias and to ensure independence. Accordingly, the Claim Administrator must contract within at least (3) IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

- a. Utilization of legal experts where appropriate to make coverage determinations under the plan.
- b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
- c. Within 5 business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within 1 business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.

- d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within 1 business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claim Administrator.
- e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
- (1) Your medical records;
 - (2) The attending health care professional's recommendation;
 - (3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;
 - (4) The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
 - (5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - (6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
 - (7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent

the information or documents are available and the clinical reviewer or reviewers consider appropriate.

- f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claim Administrator and you or your authorized representative.
- g. The notice of final external review decision will contain:
 - (1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - (2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - (3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 - (4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - (5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator and you or your authorized representative;
 - (6) A statement that judicial review may be available to you or your authorized representative; and
 - (7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
- h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. Reversal of plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claim Administrator immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

EXPEDITED EXTERNAL REVIEW

- 1. Request for expedited external review.** Claim Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claim Administrator at the time you receive:
 - a.** An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
 - b.** A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.
- 2. Preliminary review.** Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in STANDARD EXTERNAL REVIEW section above.
- 3. Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process.
- 4. Notice of final external review decision.** The Claim Administrator's contract with the assigned IRO must require the IRO to provide notice of

the final external review decision, in accordance with the requirements set forth in the STANDARD EXTERNAL REVIEW section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

EXHAUSTION

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the Claim Administrator to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

GENERAL PROVISIONS

1. CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Claim Administrator hereby informs you that it has contracts with certain Providers (“Administrator Providers”) in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under the Health Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

- receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claim Administrator was obligated to pay the Administrator Provider, or
- pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Administrator Providers other substantial allowances under the Claim Administrator’s contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by the Claim Administrator as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet shall be based on the Eligible Charge or Provider’s Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage (“ADP”) applicable to your Claim or Claims. Your Employer has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how the Claim Administrator’s separate financial arrangements with Providers work, please consider the following example:

- a. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is \$1,000. How is the \$1,000 bill paid?
- b. You personally will have to pay the deductible and Coinsurance amounts set out in your benefit booklet.
- c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital’s Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the \$1,000 Hospital bill would be reduced by 30% to \$700 for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

- d. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the \$1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of \$700, or \$140. You should note that your 20% Coinsurance is based on the full \$1,000 Hospital bill, after it is reduced by the applicable ADP.
- e. After taking into account the deductible and Coinsurance amounts, the Claim Administrator will satisfy its portion of the Hospital bill. In most cases, the Claim Administrator has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money the Claim Administrator would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is \$1,000, your deductible has already been satisfied, and your Coinsurance is \$140, then the Claim Administrator has to satisfy the rest of the Hospital bill, or \$860. Assuming the Claim Administrator has a contract with the Hospital, the Claim Administrator will usually be able to satisfy the \$860 bill that remains after your Coinsurance and deductible, by paying less than \$860 to the Hospital, often substantially less than \$860. The Claim Administrator receives, and keeps for its own account, the difference between the \$860 bill and whatever the Claim Administrator ultimately pays under its contracts with Administrator Providers, and neither you nor your Employer are entitled to any part of these savings.

Other Blue Cross and Blue Shields' Separate Financial Arrangements with Providers

Blue Card

The Claim Administrator hereby informs you that other Blue Cross and Blue Shield Plans outside of Illinois ("Host Blue") may have contracts similar to the contracts described above with certain Providers ("Host Blue Providers") in their service area.

When you receive health care services through BlueCard outside of Illinois and from a Provider which does not have a contract with the Claim Administrator, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue passes on to the Claim Administrator.

To help you understand how this calculation would work, please consider the following example:

- a. Suppose you receive covered medical services for an illness while you are on vacation outside of Illinois. You show your identification card to the provider to let him or her know that you are covered by the Claim Administrator.

- b. The provider has negotiated with the Host Blue a price of \$80, even though the provider's standard charge for this service is \$100. In this example, the provider bills the Host Blue \$100.
- c. The Host Blue, in turn, forwards the claim to the Claim Administrator and indicates that the negotiated price for the covered service is \$80. The Claim Administrator would then base the amount you must pay for the service – the amount applied to your deductible, if any, and your coinsurance percentage – on the \$80 negotiated price, not the \$100 billed charge.
- d. So, for example, if your coinsurance is 20%, you would pay \$16 (20% of \$80), not \$20 (20% of \$100). You are not responsible for amounts over the negotiated price for a covered service.

PLEASE NOTE: The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this benefit booklet.

Often, this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that factors into the actual price increases or reductions to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, the Claim Administrator would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Servicing Plans

In some instances, the Claim Administrator has entered into agreements with other Blue Cross and Blue Shield Plans (“Servicing Plans”) to provide, on the Claim Administrator's behalf, Claim Payments and certain administrative services for you. Under these agreements, the Claim Administrator will reimburse each Servicing Plan for all Claim Payments made on the Claim Administrator's behalf for you.

Certain Servicing Plans may have contracts similar to the contracts described above with certain Providers (“Servicing Plan Providers”) in their service area. The Servicing Plan will process your claim in accordance with the Servicing Plan’s applicable contract with the Servicing Plan Provider. Further, all amounts payable to the Servicing Plan by the Claim Administrator for Claim Payments made by the Servicing Plan and applicable service charges, and all benefit maximum amounts and any required deductible and Coinsurance amounts under this Health Care Plan will be calculated on the basis of the Servicing Plan Provider’s Eligible Charge for Covered Services rendered to you or the cost agreed upon between the Servicing Plan and the Claim Administrator for Covered Services that the Servicing Plan passes to the Claim Administrator, whichever is lower.

Often, the agreed upon cost is a simple discount. Sometimes, however, the agreed upon cost may represent either an estimated discount or an average discount received or expected by the Servicing Plan based on separate financial arrangements with Servicing Plan Providers.

In other instances, laws in a small number of states dictate the basis upon which the Coinsurance is calculated. When Covered Services are rendered in those states, the Coinsurance amount will be calculated using the state’s statutory method.

Claim Administrator’s Separate Financial Arrangements with Prescription Drug Providers

The Claim Administrator hereby informs you that it has contracts, either directly or indirectly, with Prescription Drug Providers (“Participating Prescription Drug Providers”) to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under this Health Care Plan. Under its contracts with Participating Prescription Drug Providers, the Claim Administrator may receive from these Providers discounts for prescription drugs dispensed to you. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances.

Claim Administrator’s Separate Financial Arrangements with Pharmacy Benefit Managers

The Claim Administrator owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the Claim Administrator has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as “Pharmacy Benefit Managers”) to provide, on the Claim Administrator’s behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of such rebates as they are figured into the pricing of the product.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

- a. Under this Health Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. The Claim Administrator is specifically authorized by you to determine to whom any benefit payment should be made.
- b. Once Covered Services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.
- c. A Covered Person's claim for benefits under this Health Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person. Coverage under this Health Care Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

3. YOUR PROVIDER RELATIONSHIPS

- a. The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.
- b. The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.
- c. The use of an adjective such as Participating, Administrator or approved in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Participating, Administrator, approved or any similar modifier or the use of a term such as Non-Administrator or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.
- d. Each Provider provides Covered Services only to you and does not deal with or provide any services to your Employer (other than as an individ-

ual Covered Person) or your Employer's ERISA Health Benefit Program.

4. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Health Care Plan as described in this benefit booklet must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this benefit booklet for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator's records or in care of your Employer and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

5. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Health Care Plan as described in this benefit booklet, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet.

6. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under the Health Care Plan, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Claim Administrator or its agent, and agree that any such Provider, person or other entity may furnish to the Claim Administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Claim Administrator may furnish similar information and records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish the Claim Administrator and/or your Employer or group administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the Claim Administrator be able to make Claim Payments in accordance with MSP laws.

REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to negligence of a third party and benefits are provided for Covered Services described in this benefit booklet, you agree:

- a. the Claim Administrator has the rights to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which the Claim Administrator has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.
- b. the Claim Administrator is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Claim Administrator provided for that sickness or injury.

The Claim Administrator shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses for which the Claim Administrator has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability. (See provisions of this benefit booklet regarding "Claim Administrator's Separate Financial Arrangements with Providers.")

END OF BENEFIT BOOKLET

The information which follows is provided to you by BRG Sports, Inc.. The Claim Administrator is not responsible for its contents.

**EMPLOYEE RETIREMENT INCOME
SECURITY ACT OF 1974
PLAN ADMINISTRATION INFORMATION**

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet. Your Plan Administrator has determined that this information together with the information contained in your booklet is the Summary Plan Description required by ERISA.

In furnishing this information, the Claim Administrator is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

NAME OF PLAN:

BRG Sports Welfare Benefit Plan

PLAN SPONSOR:

Name:	BRG Sports, Inc.
Address:	6225 North State Highway 161 Irving, TX 75038

PLAN NUMBER:

501

PLAN ADMINISTRATOR:

Name:	BRG Sports, Inc.
Address:	6225 North State Highway 161 Irving, TX 75038
Telephone Number:	(469) 417-6605

TYPE OF PLAN:

Welfare Benefit Plan

TYPE OF PLAN ADMINISTRATION:

The benefits are self-funded by BRG Sports, Inc. Claims are processed by Blue Cross and Blue Shield of Illinois.

CLAIM ADMINISTRATION:

Claims for benefits should be directed to:

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

AGENT FOR SERVICE OF LEGAL PROCESS:

BRG Sports

COLLECTIVE BARGAINING AGREEMENTS:

A copy of the collective bargaining agreement can be obtained upon written request to the Plan Administrator and is available for examination.

ELIGIBILITY:

The provisions regarding participation in the Plan are explained in this booklet.

BENEFITS AND ADMINISTRATION:

Benefits are described in this booklet. However, these benefits may change from time to time.

Minimum Maternity Benefits

Group health plans and health insurance issuers offering group insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay in excess of the above periods.

LOSS OF BENEFITS, INELIGIBILITY, DISQUALIFICATION AND SUSPENSION:

The provisions regarding ineligibility, descriptions of circumstances which may result in disqualification, suspension, denial of benefits, reduction or termination of coverage are explained in this booklet.

CONTRIBUTIONS:

Both the employer and employee contribute to the Plan. Amounts are paid on a pre-tax basis in accordance with the BRG Sports Flexible Benefit Plan.

FUNDING ARRANGEMENTS:

All benefits paid under this Plan shall be paid in case from the general assets of the employer.

TERMINATION OF PLAN OR BANKRUPTCY:

Although the Plan Sponsor anticipates offering benefits under the Plan indefinitely, the Plan Sponsor reserves the right to terminate the Plan or amend or eliminate benefits under the Plan at any time.

PLAN YEAR:

01/01 – 12-31

QUALIFIED CHILD SUPPORT ORDERS:

Participants and beneficiaries can obtain, without charge, a copy of the Plan's procedures governing qualified medical support order ("QMCSO") determinations from the Plan Administrator.

NO CONTRACT OF EMPLOYMENT:

The Plan does not create a contract of employment or create any obligation of continued service of any employee.

HOW TO GET YOUR BENEFITS:

This information is explained in the section of this booklet entitled "HOW TO FILE A CLAIM."

CLAIMS PROCEDURE:

This information is explained in the section of this booklet entitled "HOW TO FILE A CLAIM".

CLAIM APPEAL PROCEDURES

This information is explained in the section of this booklet entitled "HOW TO FILE A CLAIM."

CLAIM REVIEW PROCEDURE:

This information is explained in the section of this booklet entitled "HOW TO FILE A CLAIM."

STATEMENT OF ERISA RIGHTS:

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

- a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department

of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- c. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage:

- a. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this booklet and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- b. Reduction or elimination of exclusionary periods of coverage for Preexisting Conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a certificate of Creditable Coverage, free of charge from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a preexisting exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries:

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit under the plan or exercising your rights under ERISA.

Enforce Your Rights:

If your Claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen the plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees.

If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your Claim is frivolous.

Assistance with Your Questions:

If you have any questions about the plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue, N. W., Washington, D. C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA):

Group health plans and health insurance issuers, under USERRA, must protect all persons who perform duty, voluntarily or involuntarily, in the "uniformed services", which include the Army, Navy, Marine Corps, Air Force, Coast Guard and Public Health Service commissioned corps, as well as the reserve components of each of these services. If you are a pre-service member returning from a period of service in the uniformed services, you are entitled to reemployment from your Employer if you meet the following criteria:

- you held the job prior to service;
- you gave notice to your Employer that you were leaving your employment for service in the uniformed services, unless giving notice was precluded by military necessity or otherwise impossible or unreasonable;

- your cumulative period of service did not exceed five years;
- you were not released from service under dishonorable or other punitive conditions; and
- you reported back to the job in a timely manner or submitted a timely application for reemployment.

The time limits for returning to work are as follows:

- For less than 31 days of service – by the beginning of the first regularly scheduled work period after the end of the calendar day of duty, plus time required to return home safely and an eight hour rest period. If this is impossible or unreasonable through no fault of your own, then as soon as possible;
- For 31 to 180 days of service – you must apply for reemployment no later than 14 days after completion of military service. If this is impossible or unreasonable through no fault of your own, then as soon as possible;
- For 181 days or more of service – you must apply for reemployment no later than 90 days after completion of military service;
- For service-connected injury or illness – reporting or application deadlines are extended for up to two years if you are hospitalized or convalescing.

Aviso Importante:

Para obtener informacion o para someter una queja usted puede llamar al numero de telefono gratis de Blue Cross and Blue Shield of Illinois para informacion o para someter una queja al: 1-800-892-2803. Usted tambien puede escribir a Blue Cross and Blue Shield of Illinois al: P. O. Box 805107, Chicago, Illinois 60680-4112.

Administered by:



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.™

ASO-1

Effective Date: January 1, 2014

www.bcbsil.com

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Illinois provides administrative services only and
does not assume any financial risk or obligation with respect to claims.

EXHIBIT F

Your Health Care Benefit Program



YRC Worldwide
Hourly Plan 010502

Administered by:



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.™

A message from

YRC Worldwide

This booklet describes the Health Care Plan which we provide to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your health care claims, we have engaged Blue Cross and Blue Shield of Illinois as Claim Administrator.

Please read the information in this benefit booklet carefully so you will have a full understanding of your health care benefits. If you want more information or have any questions about your health care benefits, please contact the YRC Benefits Service Center.

Sincerely,

YRC Worldwide

NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those Providers.

Please refer to the provision entitled “Claim Administrator’s Separate Financial Arrangements with Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Please note that the Claim Administrator has contracts, either directly or indirectly, with many prescription drug providers that provide the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those providers.

Please refer to the provision entitled “Claim Administrator’s Separate Financial Arrangements with Prescription Drug Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Blue Cross and Blue Shield of Illinois provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

**WARNING, LIMITED BENEFITS WILL BE PAID WHEN
NON-PARTICIPATING PROVIDERS ARE USED**

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy’s fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the plan. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED UNDER THIS COVERAGE AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

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BENEFIT HIGHLIGHTS

Your health care benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire benefit booklet.

THE UTILIZATION REVIEW PROGRAM

A special program designed to assist you in determining the course of treatment that will maximize your benefits under this benefit booklet

Lifetime Maximum
for all Benefits

Unlimited

Individual Deductible

- Participating Provider \$250 per benefit period
- Non-Participating and
Non-Administrator Provider \$2,000 per benefit period

Family Deductible

- Participating Provider \$500 per benefit period
- Non-Participating and
Non-Administrator Provider \$4,000 per benefit period

Individual Out-of-Pocket
Expense Limit

(does not apply to all services)

- Participating Provider \$2,000 per benefit period
- Non-Participating Provider \$6,000 per benefit period
- Non-Administrator Provider No limit

Family Out-of-Pocket
Expense Limit

- Participating Provider \$4,000 per benefit period
- Non-Participating Provider \$12,000 per benefit period
- Non-Administrator Provider No limit

Chiropractic and Osteopathic
Manipulation Benefit Maximum \$1,000 per benefit period

HOSPITAL BENEFITS

Payment level for Covered
Services from a
Participating Provider:

- Inpatient Covered Services 90% of the Eligible Charge,
deductible applies
- Outpatient Covered
Services 90% of the Eligible Charge,
deductible applies

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- Preventive Care 100% of the Eligible Charge,
no deductible

Payment level for Covered
Services from a

Non-Participating Provider:

- Inpatient Covered Services 60% of the Eligible Charge,
deductible applies
- Outpatient Covered Services 60% of the Eligible Charge,
deductible applies
- Preventive Care no coverage

Payment level for Covered
Services from a

Non-Administrator Provider

100% of the Non-Participating
Hospital Benefit Payment Level

Hospital Emergency Care

- Payment level for
Emergency Accident
Care from either a
Participating,
Non-Participating or
Non-Administrator Provider 90% of the Eligible Charge,
deductible applies
- Payment level for
Emergency Medical
Care from either
a Participating,
Non-Participating or
Non-Administrator Provider 90% of the Eligible Charge,
deductible applies

Non-Emergency use of the
Emergency Room

\$100 Copayment

PHYSICIAN BENEFITS

Payment level for Surgical/
Medical Covered Services

- **Participating Provider** 90% of the Maximum Allowance,
deductible applies
- **Non-Participating Provider** 60% of the Maximum Allowance,
deductible applies

Payment level for
Physician Office Visits

- Participating Provider \$20 per visit, then 100% of the
(other than a specialist) Maximum Allowance, no deductible

of 1230

- Participating Provider Specialist \$35 per visit, then 100% of the Maximum Allowance, no deductible

Payment level for Preventive Care

- Participating Provider 100% of the Maximum Allowance, no deductible
- Non-Participating Provider no coverage

Payment level for Emergency Accident Care 90% of the Maximum Allowance, deductible applies

Payment level for Emergency Medical Care 90% of the Maximum Allowance, deductible applies

OTHER COVERED SERVICES

Payment level 90% of the Eligible Charge or Maximum Allowance

TO IDENTIFY NON-ADMINISTRATOR AND ADMINISTRATOR HOSPITALS OR FACILITIES, YOU SHOULD CONTACT THE CLAIM ADMINISTRATOR BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR IDENTIFICATION CARD.

DEFINITIONS SECTION

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

ADMINISTRATOR PROGRAM.....means programs for which a Hospital has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time services are rendered to you. These programs are limited to a Partial Hospitalization Treatment Program or Coordinated Home Care Program.

ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

ADVANCED PRACTICE NURSE.....means Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist.

AMBULANCE TRANSPORTATION.....means local transportation in a specially equipped certified vehicle from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.

AMBULATORY SURGICAL FACILITY.....means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

An "Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which does not meet the definition of an Administrator Ambulatory Surgical Facility.

ANESTHESIA SERVICES.....means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them respectively.

AVERAGE DISCOUNT PERCENTAGE (“ADP”).....means a percentage discount determined by the Claim Administrator that will be applied to a Provider’s Eligible Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by the Claim Administrator to be relevant to the particular Claim. The ADP reflects the Claim Administrator’s reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect related costs. (See provisions of this benefit booklet regarding “Claim Administrator’s Separate Financial Arrangements with Providers.”) In determining the ADP applicable to a particular Claim, the Claim Administrator will take into account differences among Hospitals and other facilities, the Claim Administrator’s contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when your benefits under the Health Care Plan are secondary to Medicare and/or coverage under any other group program.

BEHAVIORAL HEALTH PRACTITIONER.....means a Physician or Professional Provider who is duly licensed to render services for Mental Illness, Serious Mental Illness or Substance Use Disorders.

CERTIFICATE OF CREDITABLE COVERAGE.....means a certificate disclosing information relating to your Creditable Coverage under a health care benefit program.

CERTIFIED CLINICAL NURSE SPECIALIST.....means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- (ii) is a graduate of an advanced practice nursing program.

A “Participating Certified Clinical Nurse Specialist” means a Certified Clinical Nurse Specialist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Clinical Nurse Specialist” means a Certified Clinical Nurse Specialist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE-MIDWIFE.....means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- (ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

A “Participating Certified Nurse-Midwife” means a Certified Nurse-Midwife who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Nurse-Midwife” means a Certified Nurse-Midwife who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE PRACTITIONER.....means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- (ii) is a graduate of an advanced practice nursing program.

A “Participating Certified Nurse Practitioner” means a Certified Nurse Practitioner who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Nurse Practitioner” means a Certified Nurse Practitioner who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED REGISTERED NURSE ANESTHETIST or CRNA.....means a nurse anesthetist who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by

the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

A “Participating Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CHEMOTHERAPY.....means the treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

CHIROPRACTOR.....means a duly licensed chiropractor.

CLAIM.....means notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

CLAIM ADMINISTRATOR.....means Blue Cross and Blue Shield of Illinois.

CLAIM CHARGE.....means the amount which appears on a Claim as the Provider’s charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding “The Claim Administrator’s Separate Financial Arrangements with Providers.”)

CLAIM PAYMENT.....means the benefit payment calculated by the Claim Administrator, after submission of a Claim, in accordance with the benefits described in this benefit booklet. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding “The Claim Administrator’s Separate Financial Arrangements with Providers.”)

CLINICAL LABORATORY.....means a clinical laboratory which complies with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, the Medicare and Medicaid programs and any applicable state and local statutes and regulations.

A “Participating Clinical Laboratory” means a Clinical Laboratory which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Laboratory” means a Clinical Laboratory which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan provide services to you at the time services are rendered.

CLINICAL PROFESSIONAL COUNSELOR.....means a duly licensed clinical professional counselor.

A “Participating Clinical Professional Counselor” means a Clinical Professional Counselor who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Professional Counselor” means a Clinical Professional Counselor who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL SOCIAL WORKER.....means a duly licensed clinical social worker.

A “Participating Clinical Social Worker” means a Clinical Social Worker who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Social Worker” means a Clinical Social Worker who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this program.

COINSURANCE.....means a percentage of an eligible expense that you are required to pay towards a Covered Service.

COMPLICATIONS OF PREGNANCY.....means all physical effects suffered as a result of pregnancy which would not be considered the effect of normal pregnancy.

COORDINATED HOME CARE PROGRAM.....means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

An "Administrator Coordinated Home Care Program" means a Coordinated Home Care Program which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time service is rendered to you.

A "Non-Administrator Coordinated Home Care Program" means a Coordinated Home Care Program which does not have an agreement with the Claim Administrator or a Blue Cross Plan but has been certified as a home health agency in accordance with the guidelines established by Medicare.

COPAYMENT.....means a specified dollar amount that you are required to pay towards a Covered Service.

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE.....means the date on which your coverage under the Health Care Plan begins.

COVERED SERVICE.....means a service and supply specified in this benefit booklet for which benefits will be provided.

CREDITABLE COVERAGE.....means coverage you had under any of the following:

- (i) a group health plan.
- (ii) Health insurance coverage for medical care under any hospital or medical service policy plan, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.
- (iii) Medicare (Parts A or B of Title XVIII of the Social Security Act).
- (iv) Medicaid (Title XIX of the Social Security Act).
- (v) Medical care for members and certain former members of the uniformed services and their dependents.

- (vi) A medical care program of the Indian Health Service or of a tribal organization.
- (vii) A State health benefits risk pool.
- (viii) A health plan offered under the Federal Employees Health Benefits Program.
- (ix) A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country.
- (x) A health plan under Section 5(e) of the Peace Corps Act.
- (xi) State Children's Health Insurance Program (Title XXI of the Social Security Act).

CUSTODIAL CARE SERVICE.....means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you.

DENTIST.....means a duly licensed dentist.

DIAGNOSTIC SERVICE.....means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

DIALYSIS FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

An "Administrator Dialysis Facility" means a Dialysis Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Dialysis Facility” means a Dialysis Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with the guidelines established by Medicare.

DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider.

A “Participating Durable Medical Equipment Provider” means a Durable Medical Equipment Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Durable Medical Equipment Provider” means a Durable Medical Equipment Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ELIGIBLE CHARGE.....means (a) in the case of a Provider, other than a Professional Provider, which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, such Provider’s Claim Charge for Covered Services and (b) in the case of a Provider, other than a Professional Provider, which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, will be the lesser of:

- (i) the Provider’s billed charges, or;
- (ii) the Claim Administrator non-contracting Eligible Charge. Except as otherwise provided in this section, the non-contracting Eligible Charge is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Eligible Charge for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating or Non-Administrator Provider’s standard billed charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Eligible Charge for Non-Participating or Non-Administrator Providers will be 50% of the Non-Participating or Non-Administrator Provider’s standard billed charge for such Covered Service.

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Provider Claims for processing Claims submitted by Non-Participating or Non-Administrator Providers

which may also alter the Eligible Charge for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

ELIGIBLE PERSON.....means an employee of the Employer who meets the eligibility requirements for this health and/or dental coverage, as described in the **ELIGIBILITY SECTION** of this benefit booklet.

EMERGENCY ACCIDENT CARE.....means the initial Outpatient treatment of accidental injuries including related Diagnostic Services.

EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (ii) serious impairment to bodily functions; or
- (iii) serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION.....means an admission for the treatment of Mental Illness or Substance Use Disorders as a result of the sudden and unexpected onset of a Mental Illness or Substance Use Disorder condition such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

EMPLOYER.....means the company with which you are employed.

ENROLLMENT DATE.....means the first day of coverage under your Employer's health plan or, if your Employer has a waiting period prior to the effective date of your coverage, the first day of the waiting period (typically, the date employment begins).

FAMILY COVERAGE.....means coverage for you and your eligible dependents under the Health Care Plan.

HOME INFUSION THERAPY PROVIDER.....means a duly licensed home infusion therapy provider.

A "Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

HOSPICE CARE PROGRAM PROVIDER.....means an organization duly licensed to provide Hospice Care Program Service.

HOSPICE CARE PROGRAM SERVICE.....means a centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility or special hospice care unit.

HOSPITAL.....means a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

An "Administrator Hospital" means a Hospital which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Hospital" means a Hospital that does not meet the definition of an Administrator Hospital.

A "Participating Hospital" means an Administrator Hospital that has an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide Hospital services to participants in the Participating Provider Option program.

A "Non-Participating Hospital" means an Administrator Hospital that does not meet the definition of a Participating Hospital.

INDIVIDUAL COVERAGE.....means coverage under the Health Care Plan for yourself but not your spouse and/or dependents.

INPATIENT.....means that you are a registered bed patient and are treated as such in a health care facility.

INVESTIGATIONAL or INVESTIGATIONAL SERVICES AND SUPPLIES.....means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

LONG TERM CARE SERVICES.....means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury or condition.

MAINTENANCE CARE.....means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY.....means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

MARRIAGE AND FAMILY THERAPIST ("LMFT").....means a duly licensed marriage and family therapist.

A "Participating Marriage and Family Therapist" means a Marriage and Family Therapist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Marriage and Family Therapist" means a Marriage and Family Therapist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

MATERNITY SERVICE.....means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

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MAXIMUM ALLOWANCE.....means (a) the amount which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Professional Providers will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. (b) For Non-Participating Professional Providers, the Maximum Allowance will be the lesser of:

- (i) the Provider's billed charges, or;
- (ii) the Claim Administrator non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Maximum Allowance for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating Professional Provider's standard billed charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Maximum Allowance for Non-Participating Professional Providers will be 50% of the Non-Participating Professional Provider's standard billed charge for such Covered Service.

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Professional Provider Claims for processing Claims submitted by Non-Participating Professional Providers which may also alter the Maximum Allowance for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

MEDICAL CARE.....means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

MEDICALLY NECESSARY.....SEE EXCLUSIONS SECTION OF THIS BENEFIT BOOKLET.

MEDICARE.....means the program established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.).

MEDICARE APPROVED or MEDICARE PARTICIPATING.....means a Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

MEDICARE SECONDARY PAYER or MSP.....means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

MENTAL HEALTH UNIT.....means a unit established to assist in the administration of Mental Illness and Substance Use Disorder Rehabilitation Treatment benefits including Preauthorization, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for Inpatient Hospital admissions for the treatment of Mental Illness and Substance Use Disorders.

MENTAL ILLNESS.....means those illnesses classified as disorders in the current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

“Serious Mental Illness”.....means the following mental disorders as classified in the current *Diagnostic and Statistical Manual* published by the American Psychiatric Association:

- (i) Schizophrenia;
- (ii) Paranoid and other psychotic disorders;
- (iii) Bipolar disorders (hypomanic, manic, depressive and mixed);
- (iv) Major depressive disorders (single episode or recurrent);
- (v) Schizoaffective disorders (bipolar or depressive);
- (vi) Pervasive developmental disorders;
- (vii) Obsessive-compulsive disorders;
- (viii) Depression in childhood and adolescence;
- (ix) Panic disorder;
- (x) Post-traumatic stress disorders (acute, chronic, or with delayed onset); and
- (xi) Anorexia nervosa and bulimia nervosa.

NON-ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

OCCUPATIONAL THERAPIST.....means a duly licensed occupational therapist.

OCCUPATIONAL THERAPY.....means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

OPTOMETRIST.....means a duly licensed optometrist.

A “Participating Optometrist” means an Optometrist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Optometrist” means an Optometrist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ORTHOTIC PROVIDER.....means a duly licensed orthotic provider.

A “Participating Orthotic Provider” means an Orthotic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Orthotic Provider” means an Orthotic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PARTIAL HOSPITALIZATION TREATMENT PROGRAM.....means a Claim Administrator approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Rehabilitation Treatment in which patients spend days or nights.

PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

PARTICIPATING PRESCRIPTION DRUG PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER OPTION.....means a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

PHARMACY.....means any licensed establishment in which the profession of pharmacy is practiced.

PHYSICAL THERAPIST.....means a duly licensed physical therapist.

PHYSICAL THERAPY.....means the treatment of a disease, injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider.

PODIATRIST.....means a duly licensed podiatrist.

PRAUTHORIZATION, PRAUTHORIZE or EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION REVIEW.....means a submission of a request to the Mental Health Unit for a determination of Medically Necessary care under this benefit booklet.

PRIVATE DUTY NURSING SERVICE.....means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PROSTHETIC PROVIDER.....means a duly licensed prosthetic provider.

A “Participating Prosthetic Provider” means a Prosthetic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Prosthetic Provider” means a Prosthetic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you.

An “Administrator Provider” means a Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Provider” means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.

A “Participating Provider” means an Administrator Hospital or Professional Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or an Administrator facility which has been designated by the Claim Administrator as a Participating Provider.

A “Non-Participating Provider” means an Administrator Hospital or Professional Provider which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or a facility which has not been designated by the Claim Administrator as a Participating Provider.

A “Professional Provider” means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist or any Provider designated by the Claim Administrator or another Blue Cross and/or Blue Shield Plan.

A “Participating Prescription Drug Provider” means a Pharmacy that has a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer its prescription drug program to provide services to you at the time you receive the services.

PSYCHOLOGIST.....means a Registered Clinical Psychologist.

Registered Clinical Psychologist means a Clinical Psychologist who is registered with the Illinois Department of Financial and Professional Regulation pursuant to the Illinois “Psychologists Registration Act” or, in a state where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program; or

is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

REGISTERED SURGICAL ASSISTANT.....means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant.

A “Participating Registered Surgical Assistant” means a Registered Surgical Assistant who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Registered Surgical Assistant” means a Registered Surgical Assistant who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

RENAL DIALYSIS TREATMENT.....means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

RESIDENTIAL TREATMENT CENTER.....means a facility setting offering therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include halfway houses, supervised living, group homes, boarding houses or

other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with Mental Illness and/or Substance Use Disorders.

RESPITE CARE SERVICE.....means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services to you.

RETAIL HEALTH CLINIC.....means a health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by Certified Nurse Practitioners.

A “Participating Retail Health Clinic” means a Retail Health Clinic which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Retail Health Clinic” means a Retail Health Clinic which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

SKILLED NURSING FACILITY.....means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

An “Administrator Skilled Nursing Facility” means a Skilled Nursing Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Skilled Nursing Facility” means a Skilled Nursing Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with guidelines established by Medicare.

An “Uncertified Skilled Nursing Facility” means a Skilled Nursing Facility which does not meet the definition of an Administrator Skilled Nursing Facility and has not been certified in accordance with the guidelines established by Medicare.

SKILLED NURSING SERVICE.....means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

SPEECH THERAPIST.....means a duly licensed speech therapist.

SPEECH THERAPY.....means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

SUBSTANCE USE DISORDER.....means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Behavioral Health Practitioner, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

SUBSTANCE USE DISORDER TREATMENT FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment of Substance Use Disorders and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

An “Administrator Substance Use Disorder Treatment Facility” means a Substance Use Disorder Treatment Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Substance Abuse Treatment Facility” means a Substance Use Disorder Treatment Facility that does not meet the definition of an Administrator Substance Use Disorder Treatment Facility.

SURGERY.....means the performance of any medically recognized, non-investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claim Administrator.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint

linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

TOTALLY DISABLED.....means with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

ELIGIBILITY SECTION

This benefit booklet contains information about the health care benefit program for the persons who:

- Meet the following description of an Eligible Person: An Eligible Person means regular full-time and grandfathered part-time employees who are not covered by a collective bargaining agreement as defined by the Employer;
- Have applied for this coverage; and
- Have received an identification card.

If you meet this description of an Eligible Person, you are entitled to the benefits described in this benefit booklet.

MEDICARE ELIGIBLE COVERED PERSONS

If you meet the definition of an Eligible Person stated in the ELIGIBILITY Section above and you are eligible for Medicare and not affected by the “Medicare Secondary Payer” (MSP) laws as described below, the benefits described in the section of this benefit booklet entitled “Benefits for Medicare Eligible Covered Persons” will apply to you and to your spouse and covered dependent children (if he or she is also eligible for Medicare and not affected by the MSP laws).

A series of federal laws collectively referred to as the “Medicare Secondary Payer” (MSP) laws regulate the manner in which certain employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, dependent children.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer group health plan (“GHP”) coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

1. GHPs that cover individuals with end-stage renal disease (“ESRD”) during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has “current employment status.”
2. In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual’s spouse (of any age) has “current employment status.” If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).
3. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual’s family has “current employee status.” If the GHP is a multi-employer or multiple employer plan, which has at least one parti-

cipating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

PLEASE NOTE: SEE YOUR EMPLOYER OR GROUP ADMINISTRATOR SHOULD YOU HAVE ANY QUESTIONS REGARDING THE ESRD PRIMARY PERIOD OR OTHER PROVISIONS OF MSP LAWS AND THEIR APPLICATION TO YOU, YOUR SPOUSE OR ANY DEPENDENTS.

YOUR MSP RESPONSIBILITIES

In order to assist your employer in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from the Claim Administrator and/or your employer regarding the Medicare eligibility of you, your spouse and covered dependent children. In addition, if you, your spouse or covered dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact your employer or your group administrator promptly to ensure that your Claims are processed in accordance with applicable MSP laws.

YOUR ID CARD

You will receive an identification card. This card will tell you your identification number and will be very important to you in obtaining your benefits.

INDIVIDUAL COVERAGE

If you have Individual Coverage, only your own expenses for Covered Services are covered, not the expenses of other members of your family.

DEPENDENT COVERAGE

Your dependents may participate in your benefit plans if they are eligible. Those who are eligible include your legal spouse and child(ren). There are specific rules for who is considered an eligible dependent — your dependent could be eligible for coverage one year, but not the following year. Be sure to verify that your dependents meet the eligibility requirements described below. Supporting documentation of certain changes may be required.

Any claims paid in error from any YRC Worldwide sponsored plan(s) related to a dependent(s) subsequently deemed not to be an eligible dependent at the time a covered service is rendered, will be subject to recovery.

Eligible Dependents are defined as:

- Your legal spouse* as long as he or she is not legally separated from you;
- Your natural child(ren)** or legally adopted child(ren) — until he or she reaches his or her 26th birthday — provided he or she is not a member of the armed services. You are required to submit written evidence of dependency upon request;
- Your natural or legally adopted child(ren), who is named in a Qualified Medical Child Support Order (QMCSO);

- Your spouse's natural or legally adopted child(ren), who is named in a Qualified Medical Child Support Order (QMCSO);
- Your stepchild(ren)— until he or she reaches his or her 26th birthday — provided he or she is not a member of the armed services. You are required to submit written evidence of dependency upon request;
- Your foster child(ren) or “other legal dependent,” defined as legal guardianship— until he or she reaches his or her 26th birthday — provided he or she is not a member of the armed services. You are required to submit written evidence of dependency upon request;
- Your natural or legally adopted child(ren) over his or her 26th birthday, who is incapable of self-support, who resides with you and depends on you for support because of a physical handicap, mental retardation, developmental disability or mental illness. Your child's handicap must have occurred prior to reaching his or her 26th birthday. You must inform the Benefits Service Center 30 days prior to the date when your disabled child reaches his or her 26th birthday. Coverage is subject to approval by the insurance carrier.

* The word “spouse” refers to a person of the opposite or same-sex. A same-sex spouse is eligible for coverage only if the marriage was performed in a state in which same-sex marriage is legal.

** The word “child” refers to your and/or your spouse's biological/legally adopted child.

CHANGING COVERAGE DURING THE YEAR

You and your eligible dependents may enroll or make changes to your benefit elections if you experience a life status change. Following is a list of qualified life events and the time frame for making the qualified life event change:

- Marriage – 30 days
- Gain Dependent Child/Birth – 30 days
- Divorce/Legal Separation – 60 days
- Spouse Becomes Unemployed or Significant Changes to Spouse Coverage – 30 days
- Spouse Becomes Employed – 30 days
- Covered Dependent Child no Longer Eligible – 60 days
- Death of a Spouse – 30 days
- Death of a Dependent Child – 30 days

There are important time requirements governing special enrollments. If you process a life event change within the time frame allowed, the change will be effective as of the date of the event.

If you attempt to initiate the change after the time frame allowed for the qualifying event, you must wait until the next Annual Enrollment to make changes to your coverage.

The change you make must be consistent with the life event that occurred, such as adding coverage for a new spouse or baby, or dropping coverage for a spouse in a divorce. In addition, if you are not enrolled in the plan as an employee, you must enroll in the plan when you enroll any of these dependents. If your spouse is not enrolled in the plan, you may enroll him/her when you enroll a child due to birth or adoption – you can only change your coverage level and not your plan option.

When Coverage Begins

Your coverage change will be effective the date of the event if you apply for the change within the time frames shown under “CHANGING COVERAGE DURING THE YEAR”.

Late Applicants

If you do not add dependents within the time frames shown under “CHANGING COVERAGE DURING THE YEAR”, you will have to wait until the next Annual Enrollment period to make those changes. Such changes will be effective on a date that has been mutually agreed to by your Employer and the Claim Administrator.

TERMINATION OF COVERAGE

You will no longer be entitled to the benefits described in this benefit booklet if either of the events stated below should occur.

1. If you no longer meet the previously stated description of an Eligible Person.
2. If the entire coverage of your Employer terminates.

Further, termination of the agreement between the Claim Administrator and the Employer automatically terminates your coverage as described in this benefit booklet. It is the responsibility of the Employer to notify you in the event the agreement is terminated with the Claim Administrator. Regardless of whether such notice is provided, your coverage will terminate as of the effective date of termination of the Employer’s agreement with the Claim Administrator.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under the Health Care Plan described in this benefit booklet except as otherwise specifically stated in the “Extension of Benefits in Case of Termination” provisions of this benefit booklet. However, termination of the Employer agreement with the Claim Administrator and/or termination of your coverage under the Health Care Plan shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this benefit booklet, if one of your dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible.

Other options available for Continuation of Coverage are explained in the COBRA Section of this benefit booklet.

Upon termination of your coverage under the Health Care Plan, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of your or your dependent's coverage under the Health Care Plan.

UTILIZATION REVIEW PROGRAM

The Claim Administrator has established the Utilization Review Program to assist you in determining the course of treatment that will maximize your benefits under this Health Care Plan. The Utilization Review Program requires a review of the following Covered Services **before** such services are rendered:

- Inpatient Hospital services
- Skilled Nursing Facility services
- Services received in a Coordinated Home Care Program
- Private Duty Nursing Services

You are responsible for satisfying Preadmission/Admission Review requirements. This means that you must ensure that you, your family member, or Provider of services must comply with the guidelines below. The toll-free telephone number for Preadmission/Admission Review is on your ID card. Please read the provisions below very carefully.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever a nonemergency or nonmaternity Inpatient Hospital admission is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the Hospital admission.

If the proposed Hospital admission or health care services are determined to be not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised verbally of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. These letters may not be received prior to your scheduled date of admission.

- **Emergency Admission Review**

Emergency admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

In the event of an emergency admission, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days or as soon as reasonably possible after the admission has occurred.

- **Pregnancy/Maternity Admission Review**

Pregnancy/Maternity admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Health Care Plan.

In the event of a maternity admission, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days after the admission has occurred.

Even though you are not required to call the Claim Administrator prior to your maternity admission, if you call the medical pre-notification number as soon as you find out you are pregnant, the Claim Administrator will provide you information on support programs to assist you during pregnancy.

- **Skilled Nursing Facility Preadmission Review**

Skilled Nursing Facility preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care.

Whenever an admission to a Skilled Nursing Facility is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

- **Coordinated Home Care Program Preadmission Review**

Coordinated Home Care Program preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever an admission to a Coordinated Home Care Program is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

- **Private Duty Nursing Service Review**

Private Duty Nursing Service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever Private Duty Nursing Service is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to receiving services.

CASE MANAGEMENT

Case management is a collaborative process that assists you with the coordination of complex care services. A Claim Administrator case manager is available to you as an advocate for cost-effective interventions.

Case managers are also available to you to provide assistance when you need alternative benefits. Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost-effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Health Care Plan.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Upon completion of the preadmission or emergency review, the Claim Administrator will send a letter to your Physician and/or the Hospital confirming that you or your representative called the Claim Administrator and that an approved length of service or length of stay was assigned.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. In the event that the extension is determined not to be Medically Necessary, the authorization will not be extended. Additional notification will be provided to your Physician and/or the Hospital regarding the denial of payment for the extension.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the Claim Administrator. The Claim Administrator will provide notification of a decision to not authorize payment for Inpatient care or other health care services or supplies to you, your Physician, and/or the Hospital or other Provider. The notification will specify the dates, services and/or supplies that are not considered Covered Services. For further details regarding Medically Necessary care and other exclusions from coverage, see the EXCLUSIONS - WHAT IS NOT COVERED section in this benefit booklet.

The Claim Administrator does not determine your course of treatment or whether you receive particular health care services. Decisions regarding the course of treatment and receipt of particular health care services are a matter entirely between you and your Physician. The Claim Administrator's determination of Medically Necessary care is limited to merely

whether a proposed admission, continued hospitalization or other health care service is a Covered Service under the Health Care Plan.

In the event that the Claim Administrator determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service charge incurred.

Remember that the Claim Administrator's Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not determined to be Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as medically necessary, the Claim Administrator will not pay for the hospitalization, services or supplies unless the Claim Administrator determines it to be Medically Necessary and a Covered Service under the Health Care Plan.

NOTE: Keep in mind that a Medically Necessary determination does not guarantee that benefits are available. For example, it might be determined that a service is Medically Necessary, however, the Health Care Plan may limit or exclude that service. In that case, the Medically Necessary determination does not override the benefit provision in the benefit booklet.

UTILIZATION REVIEW PROCEDURE

The following information is required when you contact the Claim Administrator:

1. The name of the attending and/or admitting Physician;
2. The name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;
3. The scheduled admission and/or service date; and
4. A preliminary diagnosis or reason for the admission and/or service.

Upon receipt of the required information, the Claim Administrator:

1. will review the information provided and seek additional information as necessary.
2. will issue a determination that the services are either Medically Necessary or are not Medically Necessary.
3. will provide notification of the determination.

APPEAL PROCEDURE

If you or your Physician disagree with the determination of the Claim Administrator prior to or while receiving services, you may appeal that decision. You

should call the Claim Administrator's customer service number on your identification card. Your Physician should use the contact information in the notification letter.

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Medical Director
Health Care Service Corporation
P. O. Box A3957
Chicago, Illinois 60601

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Claim Administrator will not interfere with your relationship with any Provider. However, the Claim Administrator has established the Utilization Review Program for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits provided under this benefit booklet.

MEDICARE ELIGIBLE MEMBERS

The preadmission review provisions of this Utilization Review Program do not apply to you if you are Medicare eligible and have secondary coverage provided under the Health Care Plan.

CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT

The Claim Administrator's Mental Health Unit has been established to perform preadmission review and length of stay review for your Inpatient Hospital services for the treatment of Mental Illness and Substance Use Disorders. The Mental Health Unit is staffed primarily by Physicians, Psychologists, and registered nurses.

Failure to contact the Mental Health Unit or to comply with the determinations of the Mental Health Unit may result in a reduction of benefits. The Mental Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Behavioral Health Practitioner or Provider of services must comply with the guidelines below.

PREAUTHORIZATION REVIEW

- **Inpatient Hospital Preauthorization Review**

Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

In order to receive maximum benefits under this Health Care Plan, you must Preauthorize your nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Use Disorders by calling the Mental Health Unit. Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the Inpatient Hospital admission.

- **Emergency Mental Illness or Substance Use Disorder Admission Review**

Emergency Mental Illness or Substance Use Disorder Admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

In order to receive maximum benefits under this Health Care Plan, you or someone who calls on your behalf must notify the Mental Health Unit no later than two business days or as soon as reasonably possible after the admission for the treatment of Mental Illness or Substance Use Disorders has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits. Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

- **Partial Hospitalization Treatment Program Review**

Partial Hospitalization Treatment Program review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

In order to receive maximum benefits under this Health Care Plan, you must notify the Mental Health Unit no later than 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorders has occurred. Participating and Non-Participating Providers may call for you, when required, but it is your responsibility to ensure these requirements are satisfied. This call must be made at least 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorders has occurred. The Mental Health Unit will obtain information regarding the service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

If an Inpatient Emergency Mental Illness or Substance Use Disorders Admission occurs after a service(s), in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Mental Health Unit for an Emergency Mental Illness or Substance Use Disorder Admission Review.

- **Length of Stay/Service Review**

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Upon completion of the Preauthorization or Emergency Mental Illness or Substance Use Disorder Review, the Mental Health Unit will send you a letter confirming that you or your representative called the Mental Health Unit. A letter assigning a length of service or length of stay will be sent to your Behavioral Health Practitioner and/or the Hospital.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by the Mental Health Unit. In the event that the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to a Mental Health Unit Physician for review.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient Hospital admission or other health care services or supplies are not Medically Necessary, as such term is defined in this benefit booklet, will be determined by the Mental Health Unit. If the Mental Health Unit Physician concurs that the Inpatient Hospital admission, Outpatient service, or other health care service or supply does not meet the criteria for Medically Necessary care, some days, services or the entire hospitalization will be denied. Your Behavioral Health Practitioner and in the case of an Inpatient Hospital admissions, the Hospital will be advised by telephone of this

determinations, with a follow-up notification letter sent to you, your Behavioral Health Practitioner and the Hospital, and will specify the dates, services or supplies that are not considered Medically Necessary. The Mental Health Unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission or service. For further details regarding Medically Necessary care and other exclusions described in this benefit booklet, see the provision entitled, "EXCLUSIONS - WHAT IS NOT COVERED."

The Mental Health Unit does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Behavioral Health Practitioner. The Mental Health Unit's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is Medically Necessary under the Health Care Plan.

In the event that the Mental Health Unit determines that all or any portion of an Inpatient Hospital admission or other health care service or supply is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service or supply charge incurred.

Remember that your Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Behavioral Health Practitioner or another health care Provider may prescribe, order, recommend or approve an Inpatient Hospital admission or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Behavioral Health Practitioner prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the Mental Health Unit Physician decides they were not Medically Necessary.

MENTAL HEALTH UNIT PROCEDURE

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review you should be prepared to provide the following information:

1. the name of the attending and/or admitting Behavioral Health Practitioner;
2. the name of the Hospital or facility where the admission and/or service has been scheduled, when applicable;
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission and /or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review, the Mental Health Unit:

1. will review the medical information provided and follow-up with the Behavioral Health Practitioner;
2. upon request, will advise you of Participating Providers in the area who may be able to provide the admission and/or services that are the subject of the Preauthorization Review;
3. may determine that the admission and/or services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

Expedited Appeal

If you or your Behavioral Health Practitioner disagrees with the determinations of the Mental Health Unit prior to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Mental Health Unit and requesting an expedited appeal. The Mental Health Unit Physician will review your case and determine whether the service was Medically Necessary. You and/or your Behavioral Health Practitioner will be notified of the Mental Health Unit Physician's determination within twenty-four (24) hours or no later than the last authorized day. If you or your Behavioral Health Practitioner still disagree with the Mental Health Unit Physician, you may request an appeal in writing as outlined below.

Written Appeal

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after Claim processing has taken place or upon receipt of the notification letter from the Mental Health Unit, you may appeal that decision by having your Behavioral Health Practitioner call the contact person indicated in the notification letter or by submitting a written request to:

Blue Cross and Blue Shield of Illinois
Appeals Coordinator
Blue Cross and Blue Shield BH Unit
P. O. Box 660240
Dallas, Texas 75266-0240
Fax Number: 1-877-361-7656

You must exercise the right to this appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to the Claim Administrator as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day

period, you may review any relevant documents held by the Claim Administrator, if you request an appointment in writing.

Within 30 days of receiving your request for review, the Claim Administrator will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO PREAUTHORIZE OR NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Mental Health Unit will not interfere with your relationship with any Behavioral Health Practitioner. However, the Mental Health Unit has been established for the specific purpose of assisting you in maximizing your benefits as described in this benefit booklet.

INDIVIDUAL BENEFITS MANAGEMENT PROGRAM ("IBMP")

In addition to the benefits described in this benefit booklet, if your condition would otherwise require continued care in a Hospital or other health care facility, provision of alternative benefits for services rendered by a Participating Provider in accordance with an alternative treatment plan may be available to you.

Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations or exclusions of the Health Care Plan.

MEDICARE ELIGIBLE MEMBERS

The provisions of the CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT section do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Health Care Plan.

THE PARTICIPATING PROVIDER OPTION

Your Employer has chosen the Claim Administrator's "Participating Provider Option" for the administration of your Hospital and Physician benefits. The Participating Provider Option is a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

As a participant in the Participating Provider Option a directory of Participating Providers is available to you. You can visit the Blue Cross and Blue Shield of Illinois Web site at www.bcbsil.com/ycrw for a list of Participating Providers. While there may be changes in the directory from time to time, selection of Participating Providers by the Claim Administrator will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided to your Employer annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Participating Provider.

Before reading the description of your benefits, you should understand the terms "Benefit Period" and "Deductible" as defined below.

YOUR BENEFIT PERIOD

Your benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first December 31st following that date.

YOUR DEDUCTIBLE

Each benefit period you must satisfy a \$250 deductible for Covered Services rendered by Participating Provider(s) and a separate \$2,000 deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Administrator Provider(s). In other words, after you have claims for Covered Services for more than the deductible amount in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.

FAMILY DEDUCTIBLE

If you have Family Coverage and your family has reached the program deductible amount of \$500 for Covered Services rendered by Participating Provider(s) and a separate \$4,000 program deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Administrator Provider(s), it will not be necessary for anyone else in your family to meet the program deductible in that benefit period. That is, for the remainder of that benefit period only, no other family member(s) is required to meet the program deductible

before receiving benefits. A family member may not apply more than the individual program deductible amount toward the family program deductible.

In any case, should two or more members of your family ever receive Covered Services as a result of injuries received in the same accident, only one program deductible will be applied against those Covered Services.

HOSPITAL BENEFIT SECTION

Expenses for Hospital care are usually the biggest of all health care costs. Your Hospital benefits will help ease the financial burden of these expensive services. This section of your benefit booklet tells you what Hospital services are covered and how much will be paid for each of these services.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

INPATIENT CARE

The following are Covered Services when you receive them as an Inpatient in a Hospital.

Inpatient Covered Services

1. Bed, board and general nursing care when you are in:
 - a semi-private room
 - a private room
 - an intensive care unit
2. Ancillary services (such as operating rooms, drugs, surgical dressings and lab work)

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery.

These tests are considered part of your Inpatient Hospital surgical stay.

Partial Hospitalization Treatment

Benefits are available for this program only if it is an Administrator Program. No benefits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by the Claim Administrator.

Coordinated Home Care

Benefits will be provided for services under a Coordinated Home Care Program.

You are entitled to benefits for 60 visits in a Coordinated Home Care Program per benefit period.

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

Participating Provider

When you receive Inpatient Covered Services from a Participating Provider or in an Administrator Program of a Participating Provider, benefits will be provided at 90% of the Eligible Charge after you have met your program deductible, unless otherwise specified in this benefit booklet. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Participating Provider

When you receive Inpatient Covered Services from a Non-Participating Provider or in an Administrator Program of a Non-Participating Provider, benefits will be provided at 60% of the Eligible Charge, after you have met your program deductible. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Administrator Provider

When you receive Inpatient Covered Services from a Non-Administrator Provider, benefits will be provided at the same benefit payment level which would have been paid had such services been received from a Non-Participating Provider.

OUTPATIENT HOSPITAL CARE

The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services

1. Surgery and any related Diagnostic Service received on the same day as the Surgery
2. Radiation Therapy Treatments
3. Chemotherapy
4. Electroconvulsive Therapy
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care

7. Emergency Accident Care—treatment must occur within 72 hours of the accident or as soon as reasonably possible.
8. Emergency Medical Care
9. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

Participating Provider

Benefits will be provided at 90% of the Eligible Charge after you have met your program deductible when you receive Outpatient Hospital Covered Services from a Participating Provider.

Non-Participating Provider

When you receive Outpatient Hospital Covered Services from a Non-Participating Provider, benefits will be provided at 60% of the Eligible Charge after you have met your program deductible.

Non-Administrator Provider

When you receive Outpatient Hospital Covered Services from a Non-Administrator Provider, benefits will be provided at the same payment level which would have been paid had such services been received from a Non-Participating Provider.

Emergency Care

Benefits for Emergency Accident Care will be provided at 90% of the Eligible Charge when you receive Covered Services from either a Participating, Non-Participating or Non-Administrator Provider.

Benefits for Emergency Accident Care will be subject to the Participating Provider program deductible.

Benefits for Emergency Medical Care will be provided at 90% of the Eligible Charge when you receive Covered Services from either a Participating, Non-Participating or Non-Administrator Provider.

Benefits for Emergency Medical Care will be subject to the Participating Provider program deductible.

When you receive Covered Services in a Participating Provider emergency room for non-emergency services, benefits for the emergency room visit are subject to a \$100 Copayment per visit. Benefits for the emergency room visit will be provided at 90% of the Eligible Charge after you have met your Participating Provider program deductible.

When you receive Covered Services in a Non-Participating Provider emergency room for non-emergency services, benefits for the emergency room visit will be provided at 60% of the Eligible charge after you have met your program deductible.

However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge whether or not you have met your program deductible. The emergency room Copayment will not apply.

**WHEN SERVICES ARE NOT AVAILABLE FROM
A PARTICIPATING PROVIDER (HOSPITAL)**

If you must receive Hospital Covered Services which the Claim Administrator has reasonably determined are unavailable from a Participating Provider, benefits for the Covered Services you receive from a Non-Participating Provider will be provided at the payment level described for a Participating Provider.

PHYSICIAN BENEFIT SECTION

This section of your benefit booklet tells you what services are covered and how much will be paid when you receive care from a Physician or other specified Professional Provider.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available under this Benefit Section, services must be Medically Necessary and you must receive such services on or after your Coverage Date.

Remember, whenever the term “you” or “your” is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Surgery

Benefits are available for Surgery performed by a Physician, Dentist or Podiatrist. However, for services performed by a Dentist or Podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under this Health Care Plan had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

1. surgical removal of complete bony impacted teeth;
2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

1. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon’s office or Ambulatory Surgical Facility.

In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.
3. Sterilization Procedures (even if they are elective).

Medical Care

Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital, a Skilled Nursing Facility, or Substance Use Disorder Treatment Facility or
2. you are a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program or
3. you visit your Physician's office or your Physician comes to your home.

Consultations

Your coverage includes benefits for consultations. The consultation must be requested by your Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who also renders Surgery or Maternity Service during the same admission.

Diabetes Self-Management Training and Education

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professionals with expertise in diabetes management. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

Diagnostic Service—Benefits will be provided for those services related to covered Surgery or Medical Care.

Emergency Accident Care—Treatment must occur within 72 hours of the accident or as soon as reasonably possible.

Emergency Medical Care

Electroconvulsive Therapy

Allergy Injections and Allergy Testing

Chemotherapy

Occupational Therapy

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

Chiropractic and Osteopathic Manipulation – Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Your benefits for chiropractic and osteopathic manipulation will be limited to a maximum of \$1,000 per benefit period.

Radiation Therapy Treatments

Speech Therapy

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. Benefits will also be provided for diagnoses of head, neck, or brain cancer.

Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician.

Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Durable Medical Equipment—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates and any other internal and permanent devices. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

Amino Acid-Based Elemental Formulas—Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is medically necessary. If you purchase the formula at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet.

Orthotic Devices

Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary. However, benefits will not be provided for foot orthotics defined as any in-shoe device designed to support the structural components of the foot during weight-bearing activities.

Outpatient Contraceptive Services

Benefits will be provided for prescription contraceptive devices, injections, implants and Outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

Benefits for prescription contraceptive devices and implants will not be subject to a calendar year maximum.

Leg, Back, Arm and Neck Braces

Prosthetic Appliances

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

1. they are required to replace all or part of an organ or tissue of the human body, or

2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required).

Routine Pediatric Hearing Examination—Benefits will be provided for routine pediatric hearing examinations.

Pulmonary Rehabilitation Therapy—Benefits will be provided for outpatient cardiac/pulmonary rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services.

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

The benefits provided by the Claim Administrator and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Professional Provider.

Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist, benefits will be provided at 90% of the Maximum Allowance after you have met your program deductible, unless otherwise specified in this benefit booklet. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this benefit booklet and may bill you for the difference between the Claim Administrator's benefit payment and the Provider's charge to you.

When you receive Covered Services, including allergy testing, in a Participating Provider's office (other than a specialist's office), benefits for office visits are subject to a Copayment of \$20 per visit. Benefits for office visits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

When you receive Covered Services, including allergy testing, in a Participating Provider specialist's office, benefits for office visits are subject to a Copayment of \$35 per visit. A specialist is a Professional Provider who is **not** a Behavioral Health Practitioner or a Physician in general practice, family practice, internal medicine, psychiatry, obstetrics, gynecology or pediatrics. Benefits for office visits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

Benefits for osteopathic manipulation will be provided at 90% of the Maximum Allowance, when Covered Services are received from a Participating Provider.

Benefits for osteopathic manipulation from a Participating Provider will not be subject to the program deductible.

When you receive Covered Services for allergy injections in a Participating Provider's office, benefits will be provided at 90% of the Maximum Allowance. Your program deductible will not apply.

Non-Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Non-Participating Provider, benefits will be provided at 60% of the Maximum Allowance after you have met your program deductible.

Emergency Care

Benefits for Emergency Accident Care will be provided at 90% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider after you have met your Participating Provider program deductible.

When you receive Covered Services, in a Participating Provider's office (other than a specialist's office), benefits for office visits are subject to a Copayment of \$20 per visit. Benefits for office visits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

When you receive Covered Services, in a Participating Provider specialist's office, benefits for office visits are subject to a Copayment of \$35 per visit. A specialist is a Professional Provider who is **not** a Behavioral Health Practitioner or a Physician in general practice, family practice, internal medicine, psychiatry, obstetrics, gynecology or pediatrics. Benefits for office visits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

Benefits for Emergency Medical Care will be provided at 90% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider after you have met your program deductible.

When you receive Covered Services, in a Participating Provider's office (other than a specialist's office), benefits for office visits are subject to a Copayment of \$20 per visit. Benefits for office visits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

When you receive Covered Services, in a Participating Provider specialist's office, benefits for office visits are subject to a Copayment of \$35 per visit. A specialist is a Professional Provider who is **not** a Behavioral Health Practitioner or a Physician in general practice, family practice, internal medicine, psychiatry, obstetrics, gynecology or pediatrics. Benefits for office visits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

However, Covered Services for Emergency Accident Care and Emergency Medical Care resulting from a criminal sexual assault or abuse will be paid at 100% of the Maximum Allowance whether or not you have met your program deductible. The office visit Copayment will not apply.

Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists

who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists
- other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider or the Claim Administrator.

OTHER COVERED SERVICES

OTHER COVERED SERVICES

This section of your benefit booklet describes “Other Covered Services” and the benefits that will be provided for them.

- The processing, transporting, storing, handling and administration of Blood and blood components.
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.
- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- Oxygen and its administration
- Medical and surgical dressings, supplies, casts and splints
- Hearing Aids – Benefits will be provided for hearing aids for children up to age 19, limited to two every 36 months.
- Wigs (also referred to as cranial prostheses) – Benefits will be provided for wigs due to Chemotherapy or when medically necessary.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

After you have met your program deductible, benefits will be provided at 90% of the Eligible Charge or 90% of the Maximum Allowance for any of the Covered Services described in this section. However, benefits for Ambulance transportation will be provided at 90% of the Claim Charge, after you have met your program deductible.

When you receive Other Covered Services from a Participating or Non-Participating Provider, benefits for Other Covered Services will be provided at the payment levels previously described in this benefit booklet for Hospital and Physician Covered Services.

Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists

who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Clinical Nurse Specialists

- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists
- other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider or the Claim Administrator.

SPECIAL CONDITIONS AND PAYMENTS

There are some special things that you should know about your benefits should you receive any of the following types of treatments:

HUMAN ORGAN TRANSPLANTS

Your benefits for certain human organ transplants are the same as your benefits for any other condition. However, benefits will be provided at 100% of the Eligible Charge when Covered Services are rendered by a Blue Distinction Center for Transplants (BDCT). Your program deductible will not apply. Benefits will be provided at 80% of the Eligible Charge when Covered Services are rendered by a Participating Provider, after you have met your program deductible. Benefits will be provided at 60% of the Eligible Charge when Covered Services are rendered by a Non-Participating Provider, after you have met your program deductible. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have coverage each will have their benefits paid by their own program.
- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in this benefit booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.
- If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this benefit booklet will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant Surgery.
- the evaluation, preparation and delivery of the donor organ.
- the removal of the organ from the donor.
- the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:

- **Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact the Claim Administrator by telephone before your transplant Surgery has been scheduled. The Claim Administrator will**

furnish you with the names of Hospitals which have Claim Administrator approved Human Organ Transplant Programs.

- If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this benefit booklet, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.
- Benefits for transportation and lodging are limited to a combined life-time maximum of \$10,000. The maximum amount that will be provided for lodging is \$50 per person per day.
- In addition to the other exclusions of this benefit booklet, benefits will not be provided for the following:
 - Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
 - Travel time and related expenses required by a Provider.
 - Drugs which do not have approval of the Food and Drug Administration.
 - Storage fees.
 - Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.
 - Meals.

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Claim Administrator approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization.

PREVENTIVE CARE SERVICES

Benefits will be provided for the following Covered Services and will not be subject to any deductible, Coinsurance, Copayment or maximum when such services are received from a Participating Provider:

- evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);

- immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;
- evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents;
- with respect to women, such additional preventive care and screenings, not described above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The preventive care services described above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the website at www.bcbsil.com/ycrw or contact customer service at the toll-free number on your identification card.

Examples of covered services included are routine annual physicals, immunizations, routine diagnostic medical procedures, routine EKG, routine x-ray, well child(ren) care, cancer screenings, mammograms, bone density tests, screenings for prostate cancer and colorectal cancer, smoking cessation services and healthy diet counseling and obesity screenings/counseling.

Examples of covered immunizations included are Diphtheria, Haemophilus influenza type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, rubella, Tetanus, Varicella and other immunization that is required by law for a child(ren). Allergy injections are not considered immunizations under this benefit provision.

Participating Provider

When you receive Covered Services for preventive care from a Participating Provider, benefits for preventive care will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance and will not be subject to the program deductible.

Non-Participating Provider

Benefits will not be provided when you receive Covered Services for preventive care from a Non-Participating Provider.

SKILLED NURSING FACILITY CARE

The following are Covered Services when you receive them in a Skilled Nursing Facility:

1. Bed, board and general nursing care.

2. Ancillary services (such as drugs and surgical dressings or supplies).

No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.

Benefits for Covered Services rendered in an Administrator Skilled Nursing Facility will be provided at 90% of the Eligible Charge after you have met your program deductible.

Benefits for Covered Services rendered in a Non-Administrator Skilled Nursing Facility will be provided at 60% of the Eligible Charge, once you have met your program deductible. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.

You are entitled to benefits for 120 days of care in a Skilled Nursing Facility per benefit period.

AMBULATORY SURGICAL FACILITY

Benefits for all of the Covered Services previously described in this benefit booklet are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

Benefits for services rendered by an Administrator Ambulatory Surgical Facility will be provided at 90% of the Eligible Charge. Benefits for services rendered by a Non-Administrator Ambulatory Surgical Facility will be provided at 60% of the Eligible Charge.

Benefits for Outpatient Surgery will be provided as stated above after you have met your program deductible.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT

Benefits for all of the Covered Services described in this benefit booklet are available for Substance Use Disorder Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Use Disorder Treatment Facility. Substance Use Disorder Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with the Claim Administrator or in a Non-Administrator Provider facility will be paid at the Non-Administrator Provider facility payment level.

DETOXIFICATION

Covered Services received for detoxification are not subject to the Substance Use Disorder treatment provisions specified above. Benefits for Covered Services received for detoxification will be provided under the Hospital Benefits and Physician Benefits sections of this benefit booklet, the same as for any other condition.

MENTAL ILLNESS SERVICES

Benefits for all of the Covered Services described in this benefit booklet are available for the diagnosis and/or treatment of Mental Illness disorders. Medi-

cal Care for the treatment of a Mental Illness is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license.

Benefits for all of the Covered Services described in this benefit booklet are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder. Inpatient benefits for these Covered Services will also be provided for the diagnosis and/or treatment of Inpatient Mental Illness in a Residential Treatment Center. Treatment of a Mental Illness or Substance Use Disorder is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license. Covered Services rendered in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.

MATERNITY SERVICE

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one routine Inpatient examination and c) one Inpatient hearing screening as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth).

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from the Claim Administrator for prescribing a length of stay less than 48 hours (or 96 hours).

Your coverage also includes benefits for elective abortions if legal where performed.

INFERTILITY TREATMENT

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis and/or treatment of infertility in conjunction with conception through normal intercourse or the inability to sustain a successful pregnancy.

Infertility means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. The one year requirement will be waived if your Physician determines a medical condition exists that makes conception impossible through unprotected sexual

intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to Chemotherapy or radiation treatments.

Unprotected sexual intercourse means sexual union between a male and female without the use of any process, device or method that prevents conception including, but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

Benefits for all of the Covered Services previously described in this benefit booklet are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

MASTECTOMY-RELATED SERVICES

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are not limited to:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Inpatient care following a mastectomy for the length of time determined by your attending Physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within 48 hours after discharge; and
4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.
5. The removal of breast implants when the removal of the implants is a Medically Necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury is not considered cosmetic surgery.

PAYMENT PROVISIONS

Lifetime Maximum

The total dollar amount that will be available in benefits for you is unlimited subject to the separate dollar maximums for specific Covered Services described earlier in this benefit booklet.

Cumulative Benefit Maximums

All benefits payable under this benefit booklet are cumulative. Therefore, in calculating the benefit maximums payable for a particular Covered Service or in calculating the remaining balance under the Lifetime Maximums, the Claim Administrator will include benefit payments under both this and/or any prior or subsequent Claim Administrator's benefit booklet issued to you as an Eligible Person or a dependent of an Eligible Person under this plan.

OUT-OF-POCKET EXPENSE LIMIT

There are separate Out-of-Pocket Expense Limits applicable to Covered Services received from Participating Providers and Non-Participating Providers.

For Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals \$2,000, any additional eligible Claims for Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the program deductible(s)
- the Hospital emergency room Copayments rendered by either a Participating Provider or a Non-Participating Provider
- charges accrued from emergency room services rendered by a Non-Participating Provider
- the Copayment for Physician office visits
- the Copayment for specialist's office visits
- charges for Covered Services which have a separate dollar maximum specifically mentioned in this benefit booklet
- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Administrator Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Administrator Hospital or other Non-Administrator Provider facility

- Copayments resulting from noncompliance with the provisions of the Utilization Review Program and/or the Claim Administrator's Mental Health Unit

If you have Family Coverage and your out-of-pocket expense as described above equals \$4,000 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

For Non-Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals \$6,000, any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the program deductible(s)
- charges for Covered Services which have a separate dollar maximum specifically mentioned in this benefit booklet
- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Administrator Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Administrator Hospital or other Non-Administrator Provider facility
- Copayments resulting from noncompliance with the provisions of the Utilization Review Program and/or the Claim Administrator's Mental Health Unit
- any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period.

If you have Family Coverage and your expense as described above equals \$12,000 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this plan is terminated, benefits will be provided for, and limited to, the Covered Services of this plan which are rendered by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Use Disorder Treatment Facility, Partial Hospitalization Treatment Program or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.

HOSPICE CARE PROGRAM

Your Hospital coverage also includes benefits for Hospice Care Program Service.

Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

1. Coordinated Home Care;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services – Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services;
10. Respite Care Service.

The following services are **not** covered under the Hospice Care Program:

1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
5. Transportation, including, but not limited to, Ambulance Transportation.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this benefit booklet.

Benefit Payment for Hospice Care Program Services

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same payment level as described for Inpatient Hospital Covered Services.

BENEFITS FOR MEDICARE ELIGIBLE COVERED PERSONS

This section describes the benefits which will be provided for Medicare Eligible Covered Persons who are not affected by MSP laws, unless otherwise specified in this benefit booklet (see provisions entitled “Medicare Eligible Covered Persons” in the ELIGIBILITY SECTION of this benefit booklet).

The benefits and provisions described throughout this benefit booklet apply to you, however, in determining the benefits to be paid for your Covered Services, consideration is given to the benefits available under Medicare.

The process used in determining benefits under the Health Care Plan is as follows:

1. determine what the payment for a Covered Service would be following the payment provisions of this coverage and
2. deduct from this resulting amount the amount paid or payable by Medicare. (If you are eligible for Medicare, the amount that is available from Medicare will be deducted whether or not you have enrolled and/or received payment from Medicare.) The difference, if any, is the amount that will be paid under the Health Care Plan.

When you have a Claim, you must send the Claim Administrator a copy of your Explanation of Medicare Benefits (“EOMB”) in order for your Claim to be processed. In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used.

EXCLUSIONS - WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

— **Dental procedures which are not Medically Necessary.**

PLEASE NOTE THAT IN ORDER TO PROVIDE YOU WITH DENTAL CARE BENEFITS AT A REASONABLE COST, THE PLAN PROVIDES BENEFITS ONLY FOR THOSE COVERED SERVICES FOR ELIGIBLE DENTAL TREATMENT THAT ARE MEDICALLY NECESSARY. IT DOES NOT PAY THE COST OF ANY DENTAL CARE PROCEDURES THAT THE CLAIM ADMINISTRATOR DETERMINES WERE NOT MEDICALLY NECESSARY.

No benefits will be provided for procedures which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific procedure provided to you is reasonably required, in the reasonable judgment of the Claim Administrator, for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to you. The fact that a Physician or Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Medically Necessary.

— **Hospitalization, services and supplies which are not Medically Necessary.**

No benefits will be provided for services which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of the Claim Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
- Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.

- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.

The Claim Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your health care plan. In most instances this decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's decision, your plan provides for an appeal of that decision.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, THE CLAIM ADMINISTRATOR WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY.

- Services or supplies that are not specifically mentioned in this benefit booklet.

- Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.
- Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
- Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.
- Services or supplies that do not meet accepted standards of medical and/or dental practice.
- Investigational Services and Supplies and all related services and supplies, except as may be provided under this benefit booklet for the cost of routine patient care associated with Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with a qualified cancer trial program.
- Custodial Care Service.
- Long Term Care Service.
- Respite Care Service, except as specifically mentioned under the Hospice Care Program.
- Inpatient Private Duty Nursing Service.
- Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.

- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Charges for failure to keep a scheduled visit or charges for completion of a Claim form.
- Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this benefit booklet.
- Blood derivatives which are not classified as drugs in the official formularies.
- Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this benefit booklet.
- Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.
- Routine foot care, except for persons diagnosed with diabetes.
- Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this benefit booklet.
- Maintenance Care.
- Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation.
- Hearing aids or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this benefit booklet.
- Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are covered separately under this Health Care Plan.
- Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this benefit booklet.
- Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.

- Wigs (also referred to as cranial prostheses), unless otherwise specified in this benefit booklet.
- Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this benefit booklet.
- Contraceptive Drugs.
- Reversals of sterilization.
- Services and supplies rendered or provided for the diagnosis of infertility other than in conjunction with conception through normal intercourse; specifically excluded, without limiting this exclusion, are all services and supplies related to artificial insemination and in-vitro fertilization including, but not limited to, gamete intra-fallopian transfer (GIFT).
- Gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery), including related services and supplies.
- Outpatient prescription drugs or medicines.

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies when you have health care coverage through more than one group program. The purpose of COB is to ensure that you receive all of the coverage to which you are entitled under this Health Care Plan. In other words, the total payment from all of your coverages together will never be less than what would have been paid under this Health Care Plan if no other group coverages were involved. It is your obligation to notify the Claim Administrator of the existence of such other group coverages.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

1. The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.
2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this "birthday" type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.
 - However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;
 - when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to notify the Claim Administrator, and upon its request to provide a copy, of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

In order to prevent duplicate payment of benefits for a Claim, the Claim Administrator uses the following process to determine benefits when it is the secondary payer.

- determines what the payment for service would be following the payment provisions of this coverage; and
- deducts from this resulting amount the amount paid by the primary payer. The difference is the amount that will be paid under this coverage.

The Claim Administrator has the right in administering these COB provisions to:

- pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.
- recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person or other organization.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE RIGHTS UNDER COBRA. See your employer or Group Administrator should you have any questions about COBRA.

Introduction

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period Of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension Of 18-Month Period Of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under

Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed Of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

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**CLAIM FILING AND
APPEALS PROCEDURES**

In order to obtain your benefits under this benefit program, it is necessary for a Claim to be filed with the Claim Administrator. To file a Claim, usually all you will have to do is show your ID card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember however, it is your responsibility to ensure that the necessary Claim information has been provided to the Claim Administrator.

Once the Claim Administrator receives your Claim, it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how your benefits were calculated. In some cases the Claim Administrator will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from your Employee Benefits Department or from the Claim Administrator's office.
2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge.
3. Mail the completed Claim Form with attachments to:

Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, Illinois 60680-4112

In any case, Claims should be filed with the Claim Administrator on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished the succeeding calendar year.) **Claims not filed within the required time period will not be eligible for payment.**

Should you have any questions about filing Claims, ask your Employee Benefits Department or call the Claim Administrator's office.

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIMS DETERMINATIONS

The Claim Administrator will usually pay all Claims within 30 days of receipt of all information required to process a Claim. The Claim Administrator will usually notify you, your valid assignee or your authorized representative, when all information required to pay a Claim within 30 days of the Claim's

receipt has not been received. (For information regarding assigning benefits, see “Payment of Claims and Assignment of Benefits” provisions in the GENERAL PROVISIONS section of this benefit booklet.) If you fail to follow the procedures for filing a pre-service claim (as defined below), you will be notified within 5 days (or within 24 hours in the case of a failure regarding an urgent care/expedited clinical claim [as defined below]). Notification may be oral unless the claimant requests written notification.

If a Claim Is Denied or Not Paid in Full

If a claim for benefits is denied in whole or in part, you will receive a notice from the Claim Administrator within the following time limits:

1. For non-urgent pre-service claims, within 15 days after receipt of the claim by the Claim Administrator. A “pre-service claim” is any non-urgent request for benefits or for a determination, with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
2. For post-service Claims, within 30 days after receipt of the Claim by the Claim Administrator. A “post-service claim” is a Claim as defined above.

If the Claim Administrator determines that special circumstances require an extension of time for processing the claim, for non-urgent pre-service and post-service claims, the Claim Administrator shall notify you or your authorized representative in writing of the need for extension, the reason for the extension, and the expected date of decision within the initial period. In no event shall such extension exceed 15 days from the end of such initial period. If an extension is necessary because additional information is needed from you, the notice of extension shall also specifically describe the missing information, and you shall have at least 45 days from receipt of the notice within which to provide the requested information.

If the claim for benefits is denied in whole or in part, you or your authorized representative shall be notified in writing of the following:

- a. The reasons for denial;
- b. A reference to the benefit plan provisions on which the denial is based;
- c. A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
- d. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), diagnosis, treatment and denial codes with their meanings and the standards used;
- e. An explanation of the Claim Administrator’s internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if

any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;

- f. In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other benefit information may be available in such non-English language(s);
 - g. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
 - h. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
 - i. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
 - j. In the case of a denial of an urgent care/expedited clinical claim, a description of the expedited review procedure applicable to such claims. An urgent care/expedited claim decision may be provided orally, so long as written notice is furnished to the claimant within 3 days of oral notification;
 - k. Contact information for applicable office of health insurance consumer assistance or ombudsman.
3. For benefit determinations relating to urgent care/expedited clinical claim (as defined below), such notice will be provided no later than 24 hours after the receipt of your claim for benefits, unless you fail to provide sufficient information. You will be notified of the missing information and will have no less than 48 hours to provide the information. A benefit determination will be made within 48 hours after the missing information is received.
4. For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your claim for benefits.

An "urgent care/expedited clinical claim" is any pre-service claim for benefits for medical care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

INQUIRIES AND COMPLAINTS

An **“Inquiry”** is a general request for information regarding claims, benefits, or membership.

A **“Complaint”** is an expression of dissatisfaction by you either orally or in writing.

The Claim Administrator has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to, the following:

- Claims
- Quality of care

When your Complaint relates to dissatisfaction with a claim denial (or partial denial), then you have the right to a claim review/appeal as described in the CLAIM APPEAL PROCEDURES.

To pursue an Inquiry or a Complaint, you may contact **Customer Service** at the number on the back of your ID card, or you may write to:

**Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, Illinois 60601**

When you contact Customer Service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of receipt by Customer Service. Sometimes the acknowledgement and the response will be combined. If the Claim Administrator needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information, you will be contacted.

An appeal is an oral or written request for review of an Adverse Benefit Determination (as defined below) or an adverse action by the Claim Administrator, its employees or a participating provider.

CLAIM APPEAL PROCEDURES - DEFINITIONS

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on your own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your ID card.

An **“Adverse Benefit Determination”** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator or your Employer

and the Claim Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination of the Employer's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

In addition, an Adverse Benefit Determination, also includes an "Adverse Determination." An **"Adverse Determination"** means a determination by the Claim Administrator or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a Covered Service has been reviewed and, based upon the information provided, does not meet the Claim Administrator's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. For purposes of this benefit program, we will refer to both an Adverse Determination and an Adverse Benefit Determination as an Adverse Benefit Determination, unless indicated otherwise.

A **"Final Internal Adverse Benefit Determination"** means an Adverse Benefit Determination that has been upheld by the Claim Administrator or your Employer at the completion of the Claim Administrator's or Employer's internal review/appeal process.

CLAIM APPEAL PROCEDURES

If you have received an Adverse Benefit Determination, you may have your Claim reviewed on appeal. The Claim Administrator will review its decision in accordance with the following procedures. The following review procedures will also be used for Claim Administrator's (i) coverage determinations that are related to non-urgent care that you have not yet received if approval by your plan is a condition of your opportunity to maximize your benefits and (ii) coverage determinations that are related to care that you are receiving at the same time as the determination. Claim reviews are commonly referred to as "appeals."

Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the Claim Administrator to request a claim review. The Claim Administrator will need to know the reasons why you do not agree with the Adverse Benefit Determination. You may call 1-877-284-9302 or send your request to:

Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690

In support of your Claim review, you have the option of presenting evidence and testimony to the Claim Administrator, by phone or in person at a location of the Claim Administrator's choice. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive

notice of an Adverse Benefit Determination or at any time during the Claim review process.

The Claim Administrator will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of your Claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale and information will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. The appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors, but who were not involved in making the initial denial of your Claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator or your Employer.

Urgent Care/Expedited Clinical Appeals

If your appeal relates to an urgent care/expedited clinical claim, or health care services, including but not limited to, procedures or treatments ordered by a health care provider, the denial of which could significantly increase the risk to the claimant's health, then you may be entitled to an appeal on an expedited basis. Before authorization of benefits for an ongoing course of treatment is terminated or reduced, the Claim Administrator will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an urgent care/expedited pre-service or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Claim Administrator shall render a determination on the appeal within 24 hours after it receives the requested information.

Other Appeals

Upon receipt of a non-urgent pre-service or post-service appeal the Claim Administrator shall render a determination of the appeal within 30 days after the appeal has been received by the Claim Administrator or such other time as required or permitted by law.

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters at 1-800-538-8833. The Claim Administrator offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

of 1230
Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9431, or call the number on the back of your ID card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Notice of Appeal Determination

The Claim Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, orally of its determination followed-up by a written notice of the determination.

The written notice will include:

1. The reasons for the determination;
2. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), and information about how to obtain diagnosis, treatment and denial codes with their meanings;
4. An explanation of the Claim Administrator's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal;
5. In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other benefit information may be available in such non-English language(s);
6. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
7. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
8. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;

9. A description of the standard that was used in denying the claim and a discussion of the decision.

If the Claim Administrator's or your Employer's decision is to continue to deny or partially deny your Claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the INDEPENDENT EXTERNAL REVIEW section below.

If an appeal is not resolved to your satisfaction, you may appeal the Claim Administrator's decision to the Illinois Department of Insurance. The Illinois Department of Insurance will notify the Claim Administrator of the appeal. The Claim Administrator will have 21 days to respond to the Illinois Department of Insurance.

Some of the operations of the Claim Administrator are regulated by the Illinois Department of Insurance. Filing an appeal does not prevent you from filing a Complaint with the Illinois Department of Insurance or keep the Illinois Department of Insurance from investigating a Complaint.

You must exercise the right to internal appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity. If you have an adverse appeal determination, you may file civil action in a state or federal court.

STANDARD EXTERNAL REVIEW

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO).

An "**Adverse Benefit Determination**" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator or your Employer and the Claim Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination of the Employer's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

A "**Final Internal Adverse Benefit Determination**" means an Adverse Benefit Determination that has been upheld by the Claim Administrator at the completion of the Claim Administrator's internal review/appeal process.

1. **Request for external review.** Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Ad-

verse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review. If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. **Preliminary review.** Within 5 business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:
 - a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
 - b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
 - c. You have exhausted the Claim Administrator's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the **EXHAUSTION** section below for additional information and exhaustion of the internal appeal process; and
 - d. You or your authorized representative have provided all the information and forms required to process an external review.

You will be notified within 1 business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

3. **Referral to Independent Review Organization.** When an eligible request for external review is completed within the time period allowed, Claim Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the Claim Administrator will take action against bias and to ensure independence. Accordingly, the Claim Administrator must contract within at least (3) IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO

may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

- a. Utilization of legal experts where appropriate to make coverage determinations under the plan.
- b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
- c. Within 5 business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within 1 business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.
- d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within 1 business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claim Administrator.
- e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals pro-

cess applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- (1) Your medical records;
 - (2) The attending health care professional's recommendation;
 - (3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;
 - (4) The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
 - (5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - (6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
 - (7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claim Administrator and you or your authorized representative.
- g. The notice of final external review decision will contain:
- (1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - (2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - (3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

- (4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- (5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator and you or your authorized representative;
- (6) A statement that judicial review may be available to you or your authorized representative; and
- (7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. Reversal of plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claim Administrator immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

EXPEDITED EXTERNAL REVIEW

1. Request for expedited external review. Claim Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claim Administrator at the time you receive:

- a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in STANDARD EXTERNAL REVIEW section above.
3. **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process.

4. **Notice of final external review decision.** The Claim Administrator's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the STANDARD EXTERNAL REVIEW section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

EXHAUSTION

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the Claim Administrator to com-

ply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

GENERAL PROVISIONS

1. CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Claim Administrator hereby informs you that it has contracts with certain Providers (“Administrator Providers”) in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under the Health Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

- receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claim Administrator was obligated to pay the Administrator Provider, or
- pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Administrator Providers other substantial allowances under the Claim Administrator’s contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by the Claim Administrator as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet shall be based on the Eligible Charge or Provider’s Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage (“ADP”) applicable to your Claim or Claims. Your Employer has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how the Claim Administrator’s separate financial arrangements with Providers work, please consider the following example:

- a. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is \$1,000. How is the \$1,000 bill paid?
- b. You personally will have to pay the deductible and Coinsurance amounts set out in your benefit booklet.
- c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital’s Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the \$1,000 Hospital bill would be reduced by 30% to \$700 for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

- d. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the \$1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of \$700, or \$140. You should note that your 20% Coinsurance is based on the full \$1,000 Hospital bill, after it is reduced by the applicable ADP.
- e. After taking into account the deductible and Coinsurance amounts, the Claim Administrator will satisfy its portion of the Hospital bill. In most cases, the Claim Administrator has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money the Claim Administrator would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is \$1,000, your deductible has already been satisfied, and your Coinsurance is \$140, then the Claim Administrator has to satisfy the rest of the Hospital bill, or \$860. Assuming the Claim Administrator has a contract with the Hospital, the Claim Administrator will usually be able to satisfy the \$860 bill that remains after your Coinsurance and deductible, by paying less than \$860 to the Hospital, often substantially less than \$860. The Claim Administrator receives, and keeps for its own account, the difference between the \$860 bill and whatever the Claim Administrator ultimately pays under its contracts with Administrator Providers, and neither you nor your Employer are entitled to any part of these savings.

Other Blue Cross and Blue Shields' Separate Financial Arrangements with Providers

Blue Card

The Claim Administrator hereby informs you that other Blue Cross and Blue Shield Plans outside of Illinois ("Host Blue") may have contracts similar to the contracts described above with certain Providers ("Host Blue Providers") in their service area.

When you receive health care services through BlueCard outside of Illinois and from a Provider which does not have a contract with the Claim Administrator, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue passes on to the Claim Administrator.

To help you understand how this calculation would work, please consider the following example:

- a. Suppose you receive covered medical services for an illness while you are on vacation outside of Illinois. You show your identification card to the provider to let him or her know that you are covered by the Claim Administrator.

- b. The provider has negotiated with the Host Blue a price of \$80, even though the provider's standard charge for this service is \$100. In this example, the provider bills the Host Blue \$100.
- c. The Host Blue, in turn, forwards the claim to the Claim Administrator and indicates that the negotiated price for the covered service is \$80. The Claim Administrator would then base the amount you must pay for the service – the amount applied to your deductible, if any, and your coinsurance percentage – on the \$80 negotiated price, not the \$100 billed charge.
- d. So, for example, if your coinsurance is 20%, you would pay \$16 (20% of \$80), not \$20 (20% of \$100). You are not responsible for amounts over the negotiated price for a covered service.

PLEASE NOTE: The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this benefit booklet.

Often, this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that factors into the actual price increases or reductions to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, the Claim Administrator would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Servicing Plans

In some instances, the Claim Administrator has entered into agreements with other Blue Cross and Blue Shield Plans (“Servicing Plans”) to provide, on the Claim Administrator’s behalf, Claim Payments and certain administrative services for you. Under these agreements, the Claim Administrator will reimburse each Servicing Plan for all Claim Payments made on the Claim Administrator’s behalf for you.

Certain Servicing Plans may have contracts similar to the contracts described above with certain Providers (“Servicing Plan Providers”) in their service area. The Servicing Plan will process your claim in accordance with the Servicing Plan’s applicable contract with the Servicing Plan Provider. Further, all amounts payable to the Servicing Plan by the Claim Administrator for Claim Payments made by the Servicing Plan and applicable service charges, and all benefit maximum amounts and any required deductible and Coinsurance amounts under this Health Care Plan will be calculated on the basis of the Servicing Plan Provider’s Eligible Charge for Covered Services rendered to you or the cost agreed upon between the Servicing Plan and the Claim Administrator for Covered Services that the Servicing Plan passes to the Claim Administrator, whichever is lower.

Often, the agreed upon cost is a simple discount. Sometimes, however, the agreed upon cost may represent either an estimated discount or an average discount received or expected by the Servicing Plan based on separate financial arrangements with Servicing Plan Providers.

In other instances, laws in a small number of states dictate the basis upon which the Coinsurance is calculated. When Covered Services are rendered in those states, the Coinsurance amount will be calculated using the state’s statutory method.

Claim Administrator’s Separate Financial Arrangements with Prescription Drug Providers

The Claim Administrator hereby informs you that it has contracts, either directly or indirectly, with Prescription Drug Providers (“Participating Prescription Drug Providers”) to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under this Health Care Plan. Under its contracts with Participating Prescription Drug Providers, the Claim Administrator may receive from these Providers discounts for prescription drugs dispensed to you.

Claim Administrator’s Separate Financial Arrangements with Pharmacy Benefit Managers

The Claim Administrator owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the Claim Administrator has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as “Pharmacy Benefit Managers”) to provide, on the Claim Administrator’s behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of such rebates as they are figured into the pricing of the product.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

- a. Under this Health Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. The Claim Administrator is specifically authorized by you to determine to whom any benefit payment should be made.
- b. Once Covered Services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.
- c. A Covered Person's claim for benefits under this Health Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person. Coverage under this Health Care Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

3. YOUR PROVIDER RELATIONSHIPS

- a. The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.
- b. The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.
- c. The use of an adjective such as Participating, Administrator or approved in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Participating, Administrator, approved or any similar modifier or the use of a term such as Non-Administrator or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

- d. Each Provider provides Covered Services only to you and does not deal with or provide any services to your Employer (other than as an individual Covered Person) or your Employer's ERISA Health Benefit Program.

4. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Health Care Plan as described in this benefit booklet must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this benefit booklet for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator's records or in care of your Employer and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

5. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Health Care Plan as described in this benefit booklet, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet.

6. INFORMATION AND RECORDS

You agree that it is your responsibility to ensure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under the Health Care Plan, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Claim Administrator or its agent, and agree that any such Provider, person or other entity may furnish to the Claim Administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Claim Administrator may furnish similar information and records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish the Claim Administrator and/or your Employer or group administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the Claim Administrator be able to make Claim Payments in accordance with MSP laws.

REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to negligence of a third party and benefits are provided for Covered Services described in this benefit booklet, you agree:

- a. the Claim Administrator has the rights to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which the Claim Administrator has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.
- b. the Claim Administrator is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Claim Administrator provided for that sickness or injury.

The Claim Administrator shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses for which the Claim Administrator has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability. (See provisions of this benefit booklet regarding "Claim Administrator's Separate Financial Arrangements with Providers.")

Administered by:



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.™

ASO-1

Effective Date: January 1, 2014

www.bcbsil.com/ycrw

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an Independent Licensee of the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Illinois provides administrative services only and
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EXHIBIT G



Medical Plan

January 2015

Introduction

This Summary Plan Description (SPD) describes your benefits and rights under the ITW Medical Plan (the Plan) and the claim filing and appeal procedures to follow to receive benefits. It also provides important information regarding the administration of the Plan.

The Plan includes two types of coverage:

- **Participating Provider Option (PPO)** – Your coverage if you elect to join the Plan and live in an area where a PPO network is available (see [Participating Provider Option \(PPO\)](#) on page 13). You can choose between two different coverage levels.
- **Comprehensive Major Medical (CMM)** – Your coverage if you elect to join the Plan and live in an area where a PPO network is less extensive (see [Comprehensive Major Medical \(CMM\)](#) on page 14).

If you are eligible for and covered under HMO coverage, which may be offered by some ITW business units under the ITW Medical Plan, your benefits are described under separate document(s).

About this SPD...

This SPD generally describes the benefits provided under the ITW Medical Plan. It is based on official documents that may include policies, contracts, and trust agreements, and serves as the plan document for the ITW Medical Plan until such time as a separate plan document is adopted. If any Plan provision is unclear or ambiguous, the Plan Administrator will determine how it should be applied in any given circumstance.

Features of this SPD include:

- A table of **contents** you can use to access sections within this SPD. To access a specific section in the online version, click on the section heading or page number (see [Contents](#) on page 3)
- Embedded **links** to other specified pages and sections within this SPD – as well as to external websites – which are underscored and highlighted in blue and, in the online version of this SPD, can be used to reach a referenced topic, section or website.
- A **glossary** of key Plan terms, which are capitalized throughout this SPD (see [Definitions of Key Terms](#) on page 57).

This SPD describes the ITW Medical Plan as in effect on January 1, 2015. It will be effective until another SPD is issued with a later effective date. This SPD may be modified from time to time. To determine the proper benefits at any given time under the plan, you will need to consult the SPD as it was in effect at that time. In the event of any conflict between the content of this SPD and other such documents (for example, the employee portal), the terms of this SPD shall apply.

Nothing in this SPD is intended to be interpreted as a promise or guarantee of future or continued employment or as stating provisions and terms of employment. No rights accrue to any employee, dependent or beneficiary by any misstatement in, or omission from, this SPD, or by the operation of the Plan. ITW and its employees recognize their mutual right to end their employment relationship at any time and acknowledge that such relationship is one of employment at will.

In some cases, your rights under the Plan may be described in a separate document (for example, the Notice of Privacy Practices and notices about Medicare prescription drug coverage). For benefit administration purpose, these types of notices will be considered part of this SPD.

Except with respect to employment at will, ITW reserves the right to change (including, but not limited to, the right to amend, suspend, or terminate) its personnel policies, procedures, benefit plans and programs, including those for retirees, at its discretion, at any time without notice. No representative of ITW has the authority to make any agreement or representation contrary to the provisions of this SPD.

If you have any questions about eligibility and participation, contact your ITW Human Resources representative. If you have any questions about how the Plan works, contact the Medical Benefits Administrator or Pharmacy Benefits Administrator, as appropriate.

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ITW Medical Plan

Eligibility and Participation

The Plan Administrator has the absolute authority to determine eligibility for benefits and to interpret the terms of the ITW Medical Plan, in its sole discretion. The Plan Administrator's findings regarding employment status or benefits will be final, regardless of any determination by any other entity.

Eligibility

You will be eligible to participate in the ITW Medical Plan if you are:

- A regular, full-time non-union employee (regularly scheduled to work at least 30 hours per week) who is on the U.S. payroll of a Participating Business Unit; or
- An employee of a Participating Business Unit who is a member of a collective bargaining unit covered by a collective bargaining agreement which provides for your participation in the Plan.

Participating Business and Collective Bargaining Units

The list of Participating Business Units designated to participate in the ITW Medical Plan is maintained by the Employee Benefits Steering Committee of ITW and is considered part of the Plan. Unless otherwise indicated by the Employee Benefits Steering Committee, all eligible employees of a Participating Business Unit shall be allowed to participate in the Plan (as noted above).

The Employee Benefits Steering Committee may determine that any division, plant, location, facility or department which was previously designated as eligible to participate in the Plan shall thereafter be ineligible to participate under such terms and conditions as it shall deem appropriate. You can obtain a copy of this list, free of charge, by contacting the Plan Administrator.

You are considered an employee of a Participating Business Unit only if your pay is an expense of the unit.

Employees covered by a collective bargaining agreement will not be eligible to participate in the Plan unless the terms of the collective bargaining agreement specifically provide for participation in the Plan. If participation in the Plan has been negotiated for a collective bargaining unit, employees who are members of this collective bargaining unit will either be eligible to participate in the Plan or be eligible to participate in a separate plan covering such collective bargaining unit (if applicable). Employees working within a collective bargaining unit not covered under a plan that has satisfied the requirements for union decertification will not be eligible to participate in the plan until so designated by the Employee Benefits Steering Committee.

Temporary, Casual and Leased Employees and Returning Employee Consultants

An employee who is (or is treated by ITW as) employed in temporary, casual, or leased status – or who is (or is treated by ITW as) a returning employee consultant or co-op student – will not be eligible to participate in the ITW Medical Plan.

- *Temporary* means employment on a temporary basis that lasts no more than six months.
- *Casual* means employment with generally inconsistent and irregular hours and/or days, or for a predetermined period of no more than one month.
- *Leased* means contracted employment with a third-party agency.
- *Returning employee consultant* means a former employee with technical or managerial expertise who is engaged on an irregular basis and paid on an hourly basis. An employee who is or is treated by ITW as an independent contractor will not be eligible to participate.

Eligible Dependents

If you are eligible to participate in the ITW Medical Plan and elect to do so, you may enroll your eligible dependents for coverage as well. Your eligible dependents include:

- Your legal Spouse or Domestic Partner;
- Your (or your Spouse's or Domestic Partner's) Children;
- Children covered under a Qualified Medical Child Support Order (see [Qualified Medical Child Support Order \(QMCSO\)](#) on page 10); and
- Children for whom you (or your Spouse or Domestic Partner) are the sole permanent legal guardian.

You may be requested to provide proof of marriage or Domestic Partnership, or that a Child is an eligible dependent. If a dependent no longer meets the age or other dependent requirements, you must notify the ITW Benefits Service Center within 60 days (see [COBRA Continuation Coverage](#) on page 50).

Dual coverage is prohibited. You may not be covered under the ITW Medical Plan as both an employee and a dependent. If both you and your Spouse (or Domestic Partner) are covered under the ITW Medical Plan as employees, only one of you can enroll your Child(ren) as dependents under the Plan.

Participation

When you become eligible to participate in the ITW Medical Plan – for example, as a new hire or when newly eligible or re-employed – you will have 31 days in which to enroll. Your coverage will begin on the first day of the month on or after the date you become eligible for coverage (or, if you are covered by a collective bargaining agreement, the day specified in such agreement).

For example:

- If you become eligible on February 1 and enroll within 31 days, your coverage will begin February 1.
- If you become eligible on February 2 and enroll within 31 days, your coverage will begin March 1.

Changing Coverage

You will have an opportunity to change coverage for yourself, your Spouse (or Domestic Partner) or your dependent Child(ren) under the ITW Medical Plan during the open enrollment period normally held each November. If you want to enroll or change coverage effective as of the next January 1, you must meet the eligibility requirements and notify the ITW Benefits Service Center during the open enrollment period. For more information, contact the ITW Benefits Service Center.

Coverage you elect in the ITW Medical Plan must remain in effect for the entire Plan Year for which the election is made – unless you experience a change in status (see [If You Have a Change in Status](#) below).

If You Have a Change in Status

During the year, you may add or remove eligible dependents to your ITW Medical Plan coverage or cancel Plan coverage only if you experience a change in status (see listing below) and you notify the ITW Benefits Service Center within 31 days of the event. **The change you make to your elections must be consistent with and on account of that change in status.**

Change in status events include:

- Change in marital status, including marriage, divorce, legal separation, annulment, beginning or ending a Domestic Partnership, and death of a Spouse (or Domestic Partner);
- Change in number of dependents, including birth, adoption, placement for adoption, appointment of sole permanent legal guardianship, Qualified Medical Child Support Order (QMCSO), and death of dependent;
- Change in employment status (termination or commencement of employment) for you, your Spouse (or Domestic Partner), or your Child;
- Change in work schedule, including a reduction or increase in hours of employment for you, your Spouse (or Domestic Partner), or your Child, a switch between part-time and full-time status, a strike or lockout, and beginning or returning from an unpaid leave of absence;
- Change in residence or worksite for you, your Spouse (or Domestic Partner), or your Child that results in a loss of coverage;
- A dependent no longer satisfies the Plan's dependent eligibility requirements;
- Your Spouse (or Domestic Partner) or Child either becomes eligible or loses eligibility for coverage under his or her employer-sponsored plan; or there is a significant increase in the cost or significant curtailment in the coverage provided; or if your Spouse (or Domestic Partner) adds you to, or drops you from, his/her coverage during your Spouse's (or Domestic Partner's) employer's open enrollment period; or
- You, your Spouse (or Domestic Partner), or a Child becomes eligible for Medicare.

Note: The tax impact of these changes affecting Domestic Partners varies depending on whether or not the Domestic Partner is your dependent for federal income tax purposes (see [Pre-tax Premiums](#) on page 11).

Effective Date of Change in Coverage

If you request a change in coverage under the ITW Medical Plan because of birth, adoption, placement for adoption, or sole permanent legal guardianship of a Child, the change will take effect on the date of the birth, adoption, placement for adoption, or appointment of sole permanent legal guardianship. **In all other cases, any change in coverage you request will take effect on the first day of the first month on or after the date of the event.**

If a dependent no longer meets the dependent eligibility criteria (such as a divorce or a Child reaching the age limit), medical coverage for the dependent terminates at the end of the month in which the dependent becomes ineligible. It is your responsibility to notify the ITW Benefits Service Center within 60 days if this should occur. Your dependent may be eligible for coverage continuation under COBRA.

You have 31 days from the date of the qualified change in status to notify the ITW Benefits Service Center and make your benefit change. If you do not contact the ITW Benefits Service Center and make your change within 31 days of the qualified change in status event, you must wait until a subsequent qualified change in status or the next open enrollment. However, if a dependent is no longer eligible, coverage for the dependent will be discontinued retroactive to the date eligibility was lost, regardless of when the loss of eligibility was reported. For events reported after 31 days, no premiums will be refunded. ITW reserves the right to require documentation of the change in status event that triggers an enrollment right.

Special Enrollment

When You Lose Coverage

If you waive coverage under the ITW Medical Plan for yourself, your Spouse (or Domestic Partner) or eligible Children during open enrollment because you or they have other medical insurance coverage – and then you or they lose that coverage – you may be able to enroll yourself or your dependents in the ITW Medical Plan before the next open enrollment. You must contact the ITW Benefits Service Center within 31 days of the date you or your dependents:

- Lose eligibility for coverage under another group health plan – but not because you failed to make the premium payment or for cause such as filing a false claim for benefits;
- Lose the employer contribution toward another group plan's coverage; or
- Exhaust COBRA coverage – your COBRA coverage ends, but not because you failed to make the premium payment.

Coverage will be effective on the first day of the first month on or after the date of the event.

When You Have a New Dependent

If you have a new dependent as a result of marriage (or Domestic Partnership), birth, adoption, placement for adoption, or sole permanent legal guardianship, you may be able to enroll yourself and your dependents for coverage in the ITW Medical Plan provided that you request enrollment within 31 days after the marriage, birth, adoption, placement for adoption, or sole permanent legal guardianship.

- Coverage for new dependents due to marriage (or Domestic Partnership) will be effective on the first day of the first month on or after the event date (except that coverage will take effect on the date of the event if the event is on the first day of the month).

- Coverage for new dependents due to birth, adoption, placement for adoption, or sole permanent legal guardianship will be effective on the date of the birth, adoption, placement for adoption, or sole permanent legal guardianship.

In accordance with the Affordable Care Act, effective January 1, 2014, there will be no pre-existing condition limitations for you and your dependents. Therefore, the ITW Medical Plan is no longer required to issue a certificate of creditable coverage. However, you may call the Medical Benefits Administrator to request a proof of lost coverage letter.

Losing Medicaid or CHIP Coverage

If you (and/or your dependents) are covered under a Medicaid or Children's Health Insurance Program (CHIP) and Medicaid or CHIP terminates because you (and/or your dependents) lose eligibility for that coverage, you may be able to enroll yourself and your dependents for coverage under the ITW Medical Plan, provided that you request enrollment within 60 days after losing eligibility for coverage under Medicaid or CHIP.

Premium Assistance

If you are eligible for coverage under the ITW Medical Plan, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or Children's Health Insurance Programs (CHIP) to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state that offers this type of premium assistance, you can contact your state Medicaid or CHIP office to find out if premium assistance is available to you.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office, call **877.KIDS.NOW** or visit www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask if your state has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for Medicaid or CHIP premium assistance that could be used to help pay your premiums for coverage under the ITW Medical Plan, you must be permitted to enroll yourself and your dependents in these plans – as long as you and your dependents are eligible, but not already enrolled in these plans. **You must request coverage within 60 days of being determined eligible for premium assistance.** Coverage will be effective on the first day of the first month on or after the date of the event.

Extended Coverage for Disability

If you are Disabled, you will remain eligible for ITW Medical Plan coverage until you reach age 65, provided you continue to receive benefits under a long-term disability (LTD) plan offered by ITW or any ITW business unit, or you continue to receive workers' compensation benefits. You must remain Disabled and pay the required LTD premiums for your plan coverage to continue.

- For the first six months of your Disability, you would pay the active employee rate for coverage under the ITW Medical Plan.
- For the remainder of your Disability, so long as you remain eligible, you would pay a higher premium rate specifically for participants that are receiving LTD or workers' compensation benefits.
- If you elect to receive your pension while still eligible for LTD benefits and are eligible for contributions under the Retiree Health Care Contribution Plan, your rate for medical coverage will be determined as a retiree and you will no longer be eligible for the LTD premium rates.

Your dependents will be eligible for coverage during the period that you are covered.

If a covered Child is certified by a Physician and approved by the Medical Benefits Administrator as incapacitated due to physical Disability or Mental Illness before the Child age limit and is incapable of self-support, you may continue coverage for the Child after he or she attains the Child age limit as long as you are covered by the ITW Medical Plan and the Child remains incapacitated.

If you are newly eligible for medical coverage with ITW and have an incapacitated Child who is over the Child age limit, the Child is eligible for coverage only if he or she had been covered by medical insurance within the 31 days before you were hired and you enrolled the incapacitated Child in the Plan when first eligible. Proof of the incapacity may be required from time to time.

If you should remove your incapacitated Child from the ITW Medical Plan for any reason after the incapacitated Child reaches the age limit, your incapacitated Child will not be eligible to be re-enrolled in the Plan at any future date.

ITW reserves the right to require certification of Disability by a Physician appointed by ITW. If you die, coverage for your incapacitated Child may continue at his or her own expense for a temporary period (see [COBRA Continuation Coverage](#) on page 50).

Qualified Medical Child Support Orders (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is an order or judgment from a state court or administrative agency requiring coverage of your Child under the ITW Medical Plan. If the Plan Administrator receives a QMCSO, the Plan Administrator or its delegate will determine whether the order is qualified under federal law. If the order is determined to be a QMCSO, the Plan Administrator or its delegate will notify you, enroll the Child (or you and the Child) according to the terms of the order, and the Plan Administrator will deduct the necessary premiums from your paycheck required for the coverage.

Once a QMCSO is in effect, no changes to the Child's coverage will be allowed, other than as specified in the QMCSO or upon proof that the QMCSO is no longer in effect.

To be valid, an order must be approved by the Plan Administrator and must:

- Specify your name and mailing address;
- Specify the name, mailing address, date of birth and social security number of each Child covered by the order (the address of the court or agency may be substituted for the address of the Child);

- Describe the type of coverage to be provided to your Child;
- Specify each period to which the order applies; and
- Be issued by an appropriate court or agency.

A QMCSO may not require the Plan to provide benefits not otherwise provided under the Plan. To obtain a copy of the ITW Medical Plan QMCSO procedures, without charge, contact the Plan Administrator.

How the ITW Medical Plan Works

You may elect to enroll yourself and any eligible dependents in the coverage offered through the ITW Medical Plan.

Your Share of Expenses

Pre-tax Premiums

Before the beginning of each Plan Year, the Plan Administrator will notify you of the premium cost for each of the coverage options under the Plan.

Generally, any premiums paid by you – other than for certain Domestic Partner coverage – will be deducted from your pay on a pre-tax basis, through the Plan (which is a cafeteria plan under the federal tax rules). By paying your premiums pre-tax (before federal income and Social Security taxes, and usually state income taxes are withheld), you reduce your taxable income, lower the amount of taxes you pay and increase your net take-home pay. **Note:** Paying your premiums this way could reduce your Social Security benefits in the future.

Premiums for coverage of a Domestic Partner and a Domestic Partner's child(ren) must generally be paid after federal income and Social Security taxes are withheld, and the value of your employer's subsidy, if any, must be included in your taxable income. This is called imputed income. An exception will be made only for a Domestic Partner or Domestic Partner's child(ren) who qualify as your dependents for federal income tax purposes; certification of tax dependency is required.

If you have any questions about whether your Domestic Partner or his or her child(ren) will qualify, contact your tax advisor. Tax treatment at the state level may be different; check your state tax code.

The Company reserves the right to change the amount it contributes toward the cost of ITW Medical Plan coverage.

Living Well Medical Plan Premiums

To support its commitment to encouraging employee wellness, the company offers the Living Well at ITW program designed to help you improve and maintain your health. To encourage participation, the company offers medical premium discounts to participating employees.

For information on how to qualify for the lower Living Well Medical Plan premiums, refer to the Living Well at ITW tab on ITWemployee.com. Standard (non-discounted) Medical Plan premiums apply to all other employees who are enrolled for Medical Plan coverage.

For Medical Plan premiums for the current year, refer to the current Enrollment Guide.

Deductible

Each year, you pay a portion of your covered expenses before the Plan pays certain benefits. This is known as the Deductible. The annual individual Deductible and the annual family Deductible can be found in the [Summary of Benefits](#) starting on page 14. Your Out-of-Pocket Limit includes your Deductible.

The annual family Deductible is an aggregate Deductible; this means that each family member meeting covered expenses can help satisfy the annual family Deductible amount. For example: four family members could incur eligible expenses to satisfy the annual family Deductible. The maximum amount each family member can contribute toward meeting the annual family Deductible is the individual Deductible.

Coinsurance

After you meet the Deductible, you and the Plan each pay a percentage of certain covered expenses for each covered person until your share of these expenses (your Coinsurance) reaches the Plan's Out-of-Pocket Limit.

Copayment

You will be required to pay a small fee, called a Copayment, each time you receive certain services. The amount of the Copayment depends on the type of service received. Copayments do not apply toward the annual Deductible but do apply to your Out-of-Pocket Limit.

Out-of-Pocket Limit

This feature limits the amount you will pay for certain medical expenses each year for each covered family member and for your family as a whole. Your Out-of-Pocket Limit includes your Deductible, Coinsurance, and Copayments. Once you reach the annual Out-of-Pocket Limit:

- **For a family member:** The Plan generally will pay 100% of the cost of most eligible expenses for that family member for the rest of the calendar year.
- **For your family:** The Plan generally will pay 100% of the cost of most eligible expenses for all your covered family members for the rest of the calendar year.

Some expenses you pay will not apply toward your Out-of-Pocket Limit (for example, the penalty resulting from failure to notify the Medical Benefits Administrator of an inpatient hospitalization). For a complete list of expenses that do not apply to the Out-of-Pocket Limit, see [Summary of Benefits](#) starting on page 14.

Participating Provider Option (PPO)

The ITW Medical Plan offers two separate coverage options through a Participating Provider Option (PPO) network, where available – PPO Option 1 and PPO Option 2. A PPO network is a group of Physicians and medical facilities identified for a particular service area. A PPO Provider is a Physician or facility that belongs to the PPO network. PPO Providers have agreed to reduce fees when providing services to individuals covered by the Plan.

PPO Option 1 has a higher premium and lower deductibles and out-of-pocket maximums.
PPO Option 2 has a lower premium and higher deductibles and out-of-pocket maximums.

If you obtain services from a:

- **PPO Provider:** You will receive the highest level of benefits and your out-of-pocket expenses will be less than if you obtain services from a non-PPO Provider.
- **Non-PPO Provider:** Benefits will be based on the reimbursement rates used by the federal Medicare program. In addition, non-PPO Providers may bill you the difference between the Medicare reimbursement rate and their actual charge (often referred to as balance billing).

A separate Out-of-Pocket Limit applies to PPO and non-PPO Provider services.

Whether or not you use a PPO Provider is up to you; each time you or a covered dependent needs medical care you may choose to use either PPO or non-PPO Hospitals and Providers. When you choose to use non-PPO Hospitals and Providers, the Coinsurance and Out-of-Pocket Limit for non-PPO coverage will apply, except for emergency care.

PPO Provider lists are available to you without charge. For the most up-to-date list of Participating Providers, go to www.bcbsil.com/itw or call **800.325.0320**. There may be changes in the listings from time to time so be sure to check with your provider before undergoing treatment to make certain of your provider's PPO status. You can also find information about the cost of the treatment or services recommended and compare costs by provider at www.bcbsil.com/itw.

Receiving Care Outside of Your Service Area

You may access the PPO network while you are away from home. If you or your covered dependents need non-Emergency Medical Care while traveling on vacation or business, or while away at college, you should call the Medical Benefits Administrator for information on the nearest PPO doctors and Hospitals. Then, present your current ID card at the doctor's office or Hospital. The PPO Provider will verify your membership and coverage information. Be sure to carry your most recent ID card at all times.

If you need Emergency Medical Care when you are outside of your network service area, seek care at the nearest medical facility.

In the event of an emergency Inpatient Hospital admission, you must call the Medical Benefits Administrator within 48 hours of the admission or you will be responsible for the first \$500 of charges for eligible Covered Services in addition to applicable Deductible, Copayment, and Coinsurance amounts.

Also, you are responsible for contacting the Medical Benefits Administrator for precertification/prior authorization, where necessary. For more information, see [Utilization Review Programs](#) starting on page 19.

Comprehensive Major Medical (CMM)

If you elect to enroll in the ITW Medical Plan and live in an area where a PPO network is less extensive or Medicare is your primary health coverage, you will be enrolled in the Comprehensive Major Medical (CMM) plan, a component of the Plan. As a CMM participant, you will receive the PPO benefit level whether you use PPO or non-PPO providers.

If you obtain services from a:

- **PPO Provider:** After you pay any amounts that are your responsibility under the Plan's Deductible, Copayment and Coinsurance features, as well as the cost of any services that are not covered by the Plan, the Plan will pay the remaining cost of covered services based on the Plan's negotiated fees which PPO Providers have agreed to accept as full payment for their services.
- **Non-PPO Provider:** After you pay any amounts that are your responsibility under the Plan's Deductible, Copayment and Coinsurance features, as well as the cost of any services that are not covered by the Plan, the Plan will pay benefits based on the Medicare Allowance for covered services. Non-PPO Providers may bill you the difference between the Medicare Allowance and their actual charge (often referred to as balance billing).

Summary of Benefits

Use this summary for a quick reference to Plan benefits. Detailed explanations of the benefits that are covered and not covered by the Plan follow this summary.

Deductible

Per calendar year, combined PPO/Non-PPO:	PPO Option 1	PPO Option 2
• Individual Deductible	\$300	\$1,000
• Family Deductible (Aggregate)	\$600	\$2,000

Out-of-Pocket Expenses

Out-of-Pocket Limit: This is the maximum amount you will pay toward covered Hospital and medical expenses during any one calendar year, including Deductible, Coinsurance, and Copayments. The following will NOT apply to the Out-of-Pocket Limit: charges resulting from failure to notify the Medical Benefits Administrator or follow its advice, charges for services that aren't covered by the Plan, charges in excess of the Maximum Allowance, and charges for prescription drugs.		PPO Option 1 (in-network/out)	PPO Option 2 (in-network/out)
	Individual	\$2,200/\$4,800	\$4,100/\$7,500
	Family	\$4,400/\$9,600	\$8,200/\$15,000
Note: PPO expenses will only apply to the PPO Out-of-Pocket Limit and Non-PPO expenses will only apply to the Non-PPO Out-of-Pocket Limit.			

Continued...

Covered Services – Deductible applies except where noted

	Plan Pays¹:	
	PPO (Options 1 and 2)	Non-PPO (Options 1 and 2)
Adult/Child Wellness Care/Routine Physicals: Routine exams, routine x-rays and lab tests, routine eye exams and refractions, routine hearing exams, and routine immunizations.	100% ²	100% ²
Routine mammograms, routine pap smears, routine PSA tests, and routine colorectal screenings.	100% ²	100% ²
Colonoscopy	100% ²	80%
Ambulance: For emergency transportation (ground or air) by a licensed ambulance service to the closest facility where emergency health services can be performed.	80%	80%
Chiropractic Care: Up to 20 visits for muscle manipulation by any provider per calendar year per covered individual.	80%	60%
Durable Medical Equipment³: Hospital beds, wheelchairs, oxygen equipment – if medically necessary.	80%	60%
Emergency Care: Emergency Medical Care and Emergency Accident Care (initial visit). Copayment waived if admitted to Hospital from emergency room. See definition of Emergency Medical Care and Emergency Accident Care. Non-Emergency Care subject to \$100 Copayment ⁴ , Deductible, and 80% PPO and 60% non-PPO Coinsurance.	100% ² after \$100 Copayment ⁴	100% ² after \$100 Copayment ⁴
Hearing Services: The Plan covers routine hearing exam as part of Adult/Child Wellness Care. A discount program is available for hearing aids. For details, contact the Medical Benefits Administrator.	–	–
Hospital Services – Inpatient: Hospital inpatient admission is subject to \$250 Copayment. Room allowance based on the Hospital's most common semi-private room rate. For contagious diseases, the Plan pays private room rate. Covers medical and surgical care, anesthesia, laboratory and X-ray services, pre-admission testing, Skilled Nursing Facility ³ , Coordinated Home Health Care ³ and Hospice care ³ . Pre-authorization required for all inpatient admissions (see Utilization Review Programs on page 19).	80% after \$250 Copayment ⁴	60% after \$250 Copayment ⁴
Hospital Services – Outpatient (including surgery)	80%	60%
Human Organ Transplant: Human organ and tissue transplants – including bone marrow, cornea, heart, lung, heart/lung, heart valve, kidney, liver, pancreas, pancreas/kidney, muscular-skeletal and parathyroid.	80%	60%

Continued...

Covered Services – Deductible applies except where noted (cont'd.)

	Plan Pays¹:	
	PPO (Options 1 and 2)	Non-PPO (Options 1 and 2)
Maternity Care (notification required in first trimester or care subject to penalty – see Utilization Review Programs on page 19):		
• Lactation support and counseling (includes breast pump and supplies)	100% ²	100% ²
• Physician services	80%	60%
• Hospital services – pre-authorization required for all inpatient admissions (see Utilization Review Programs on page 19); inpatient hospital admission is subject to \$250 Copayment.	80% after \$250 Copayment ⁴	60% after \$250 Copayment ⁴
Mental Health and Substance Abuse Services:		
• Inpatient – pre-authorization required for all inpatient admissions (see Utilization Review Programs on page 19); inpatient hospital admission is subject to \$250 Copayment	80% after \$250 Copayment ⁴	60% after \$250 Copayment ⁴
• Outpatient Office Visit – subject to \$20 Copayment under PPO1 or \$30 Copayment under PPO2.	100% ² after Copayment ⁴	60% unless otherwise noted
Outpatient or Office Diagnostic Tests: X-rays, blood tests, CAT scans, MRIs, pre-admission testing. Also includes repeat mammogram, PSA test, PAP smear, and colonoscopy – performed on diagnostic basis. You are encouraged to obtain advance authorization. See Outpatient Diagnostic Tests on page 25.	100% ²	80% ²
Outpatient Surgery: Hospital and Health Professional services, anesthesia. Includes invasive procedures such as arthroscopy.	80%	60%
Physical, Occupational and Speech Therapy: Up to 60 visits combined per calendar year per covered individual.	80%	60%
Physician Services: Office visits and consultations – subject to \$20 Copayment under PPO1 or \$30 Copayment under PPO2.	100% ² after Copayment ⁴	60%
Vision Services: The Plan covers routine annual eye exam and refraction as part of Adult/Child Wellness Care. A discount program is available for glasses and contact lenses. For details, contact the Medical Benefits Administrator.	–	–
Other Covered Services: ³ Blood and blood components; leg, arm, back and neck braces; electroconvulsive therapy; radiation therapy and Chemotherapy; oxygen and its administration; private duty nursing (50 visit annual maximum); external prosthetic devices, orthotics and surgical dressings, supplies, casts and splints.	80%	60%

1 Benefits based on Eligible Charge or Maximum Allowance.

2 Deductible does not apply to [Preventive Care Services](#) (as described on page 26) or other noted Covered Services.

3 If PPO Provider/Participating Provider does not exist, the Plan will pay based on Maximum Allowance.

4 Copayment does not count toward Deductible, but does apply to the annual limit on out-of-pocket expenses.

Notice Regarding Women's Health and Cancer Rights Act of 1998

In compliance with federal law, the Plan provides benefits for mastectomy-related services, including coverage for:

- All stages of reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of mastectomy, including lymphedemas.

These benefits are subject to the Plan's Deductible and Coinsurance provisions.

Other Basic Provisions

Medical Benefits Administrator

The PPO network is maintained and administered by Blue Cross Blue Shield. The Medical Benefits Administrator for the ITW Medical Plan is Blue Cross Blue Shield of Illinois (BCBSIL). If you have any questions regarding your medical benefits (including questions about claims), contact BCBSIL at:

Blue Cross Blue Shield of Illinois

Full Service Unit

800.325.0320

www.bcbsil.com/itw

Utilization Review Programs

You are required to provide notice to the Medical Benefits Administrator one business day prior to all elective Inpatient Hospital admissions, all elective Inpatient mental health and Substance Abuse treatment admissions (including residential treatment centers), Skilled Nursing Facility admission or private duty nursing services. Emergency Inpatient Hospital admission notification is required within two business days after admittance. Notification is also required within the first trimester of pregnancy and again within two business days following a pregnancy related admission.

If you do not contact the Medical Benefits Administrator as required
– or if you do not comply with the determinations of the Medical Benefits Administrator –
your benefits under the Plan will be reduced. For more information, see Utilization Review Programs on page 19.

Receiving Care Outside of Your Service Area

To receive information on the nearest PPO doctors and Hospitals while you are away from home call **800.325.0320** and follow the voice prompt. You can also visit the BCBSIL website at www.bcbsil.com/itw. When you visit a PPO Provider outside of your normal service area, present your current ID card and the PPO Provider will verify your membership and coverage information.

If you need Emergency Medical Care when you are outside of your network service area, seek care at the nearest medical facility. You must call the Medical Benefits Administrator at **800.325.0320** within two business days after an emergency Inpatient Hospital admission or your benefits will be reduced. For more information, see [Utilization Review Programs](#) on page 19.

HMO Coverage

Certain business units provide Plan coverage under an HMO program. If you are employed at a business unit that provides HMO coverage, those benefits are described under such document(s) as provided by the insurance carrier and/or the business unit. Unless otherwise described in those other documents, the eligibility requirements described in this SPD shall apply.

Prescription Drug Program Benefits

Retail Network Pharmacy: Up to 30-day supply.

For maintenance medications, you are limited to an initial fill plus one refill at the retail pharmacy. The program requires that mail order be used for all maintenance medications after the initial fill plus one refill. The following prescription medications are covered at 100% in-network:

- FDA-approved generic and single-source brand contraceptives; and
- Generic tobacco cessation prescription drugs and brand-name product Chantix.

Generic: You pay \$5 Copayment

Brand: You pay 20%, not to exceed \$50 per prescription

Non-preferred Brand: You pay 30%, not to exceed \$100 per prescription

If a prescription costs less than the Copayment amount, you will be responsible for the lesser amount.

Mail Order Pharmacy: Up to 90-day supply.

The following prescription medications are covered at 100% in-network:

- FDA-approved generic and single-source brand contraceptives; and
- Generic tobacco cessation prescription drugs and brand-name product Chantix.

Generic: You pay \$15 Copayment

Brand: You pay 20%, not to exceed \$150 per prescription

Non-Preferred Brand: You pay 30%, not to exceed \$200 per prescription

If a prescription costs less than the Copayment amount, you will be responsible for the lesser amount.

Specialty Pharmacy: Up to 30-day supply.

For Specialty Medications, the Plan requires that the Specialty Pharmacy be utilized.

CVS/caremark Specialty Pharmacy can be reached at **800.238.7828**.

Generic: You pay \$5 Copayment

Brand: You pay 20%, not to exceed \$50 per prescription

Non-Preferred Brand: You pay 30%, not to exceed \$100 per prescription

If a prescription costs less than the Copayment amount, you will be responsible for the lesser amount.

Annual Out-of-Pocket Prescription Drug Maximum:

Individual	\$2,500
Family	\$5,000

Pharmacy Benefits Administrator (Retail Network and Mail Order)

The Prescription Drug Program is maintained and administered by the Pharmacy Benefits Administrator. The Pharmacy Benefits Administrator is CVS/caremark. If you have any questions regarding your pharmacy benefits (including questions about claims), contact CVS/caremark at:

CVS/caremark
888.437.4926
www.caremark.com

You may visit the Pharmacy Benefits Administrator's website at www.caremark.com to locate network pharmacies, order mail service prescription refills, check the status of your order and find answers to frequently asked questions (FAQs) about the program.

Prescription Drug Limitations

To obtain information on drugs that have prior authorization (PA), quantity limitation (QL) or step therapy protocol (STP) requirements, call CVS/caremark customer service at **888.437.4926**. For drugs requiring a medical diagnosis or PA, your pharmacist or doctor can fax the necessary information to CVS/caremark at **888.836.0730** or contact the customer service department.

Utilization Review Programs

The Utilization Review Programs use nurses and consulting Physicians to review certain services and lengths of Hospital stays. To avoid having to pay any additional out-of-pocket costs, you, a member of your family or your Physician must notify the Medical Benefits Administrator:

- Before an elective Inpatient Hospital stay – at least one business day prior to admission;
- After an Inpatient Hospital admission for Emergency Medical Care or Emergency Accident Care – within two business days after admission occurs;
- Within the first trimester of pregnancy and again after an Inpatient Hospital admission related to the pregnancy – within two business days after admission occurs; and
- Before receiving Inpatient mental health or Substance Abuse treatment (including residential treatment centers) – at least one business day prior to admission.

You can call the Medical Benefits Administrator at 800.325.0320. It is your responsibility to make sure the call is made.

When you call, the Medical Benefits Administrator may request the following information:

- Your name, group and member number (from your ID card);
- Patient's name;
- The name of the attending and/or admitting Physician;
- The name of the Hospital/facility where the admission/treatment is scheduled;
- The scheduled admission/treatment date; and
- The preliminary diagnosis or reason for the admission/treatment.

Each time you call, you should record the date, the Medical Benefits Administrator advisor's name and the file number (if provided) in case any follow-up is necessary.

If you do not contact the Medical Benefits Administrator as indicated above, you will be responsible for the first \$500 of charges for eligible Covered Services in addition to applicable Deductible, Copayment, and Coinsurance amounts. The first \$500 of charges will not apply toward your annual Out-of-Pocket Limit.

Pre-Admission Review

If your Physician recommends an Inpatient procedure, the Medical Benefits Administrator may instead recommend that you (or your covered dependent) receive treatment on an Outpatient basis. The Plan will provide benefits based on the Medical Benefits Administrator recommendation.

Length of Stay Review

After an Inpatient Hospital stay is authorized, the Medical Benefits Administrator advisor will inform you, your admitting Physician and the Hospital of the approved length of stay. If your Physician recommends a longer stay, the Hospital will contact the Medical Benefits Administrator, who will review the assigned length of stay with your Physician. They will discuss possible alternatives to an extended Hospital stay and determine whether the extended stay is Medically Necessary. **Benefits will only be paid for the length of stay recommended by the Medical Benefits Administrator advisor.**

Case Management

Case management is a collaborative process that assists you with the coordination of complex care services. Services are provided by registered nurses with specialized training and clinical experience to:

- Help explain your medical programs and treatment plans;
- Assist with transitions from one health care setting to another;
- Explain your health care benefits and how to maximize Plan benefits; and
- Help you access the right resources and services available to you.

You are encouraged to take advantage of the case management services available.

If you or your Physician disagree with the recommendations of the Medical Benefits Administrator advisor, you may appeal the decision before you receive treatment or before your Hospital stay ends (see *Appeal of Denied Claims* on page 42).

What the ITW Medical Plan Covers

You are generally covered under this Plan for care that is Medically Necessary (see [Definitions of Key Terms](#) on page 57). The rest of this section provides details on the types of care that are covered under the Plan and the limits on that care.

After you meet the annual Deductible, the Plan pays a percentage of the eligible expenses for these services and supplies. Charges over the Maximum Allowance are not Eligible Charges under the Plan. Certain factors (for

example, services not Medically Necessary) will reduce or eliminate the amount that the Plan pays (see [Limitations on Plan Benefits](#) on page 34).

For information regarding annual Deductibles, Coinsurance, Copayments and Out-of-Pocket Limits for each category of expenses covered under the Plan, see [Summary of Benefits](#) starting on page 14.

If you expect planned medical care to be costly or if you are not sure whether a service or procedure will be covered, you and/or your Provider are encouraged to contact the Medical Benefits Administrator at any time before treatment begins. The Medical Benefits Administrator will let you know whether a specific procedure or service will be covered under the Plan as well as your share of the expenses for that procedure or service. Please note however that although the Medical Benefits Administrator may tell you whether a specific procedure or service is generally covered under the Plan, this statement of coverage does not guarantee coverage under the facts and circumstances relating to your condition.

Certain benefits are subject to utilization review based on types of treatments and length of Hospital stay (see [Utilization Review Programs](#) on page 19).

Adult/Child Wellness Care/Routine Physicals

The Plan covers routine medical exams and tests including annual physicals with lab tests and x-rays, well baby visits, pre-school exams, pre-marital exams, routine eye exams and refractions by an optometrist or ophthalmologist, routine hearing tests, and flu shots and immunizations.

In addition, the Plan covers routine mammograms, routine pap smears, routine colonoscopy and colorectal screenings, routine digital rectal exams and routine prostate-specific antigen (PSA) tests.

Ambulance

The Plan covers Medically Necessary local transportation in a specially equipped certified vehicle from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, the Plan covers transportation to the closest facility that can provide the necessary service.

Chiropractic Care

The Plan covers the services of a duly licensed chiropractor, including manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation. Benefits are subject to the limits specified in the [Summary of Benefits](#) starting on page 14.

Coordinated Home Health Care

Benefits will be provided for services under a Coordinated Home Health Care program. To qualify, you must be unable to leave home without assistance and require supportive devices or special transportation and you must require skilled nursing services on an intermittent basis under the direction of your Physician. Coordinated Home Health Care does not include and is not intended to provide benefits for private duty nursing service and/or Custodial Care.

Durable Medical Equipment

Benefits will be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use such as canes, crutches, hospital beds, walkers, and wheelchairs provided that this equipment is primarily and customarily used to serve a medical purpose.

Examples of non-covered durable medical equipment items include mechanical or electrical features which serve as a convenience function, unless documentation is provided and approved as to the medical need of such items, and devices and equipment used for environmental control to enhance the environmental setting (for example, air conditioners, humidifiers, and air filters).

Emergency Care

Emergency Accident Care and Emergency Medical Care are covered, but you and your covered dependents must pay a separate Copayment for this care, which does **not** count toward the annual Deductible. **This Copayment is waived if you are admitted to the Hospital from the emergency room.** For definitions of Emergency Accident and Emergency Medical Care, see [Definitions of Key Terms](#) on page 57.

Hospice Care

Hospice care is designed to meet the needs of terminally ill patients and their families. To be eligible for Hospice care, you or your eligible dependent must have a terminal illness with a life expectancy of one year or less, as certified by the attending Physician.

Hospital Services

Covered Inpatient Hospital services are covered, but you and your covered dependents must pay a separate Copayment for this care, which does **not** count toward the annual Deductible. Covered Hospital services include:

- Room, board and general nursing care in:
 - A semi-private room
 - A private room (benefits are paid at the semi-private room rate unless certain contagious diseases are involved), or
 - An intensive care unit;
- Ancillary services (such as operating rooms, drugs, surgical dressings and lab work);
- Pre-admission testing; and
- Physician fees.

Inpatient Hospital benefits are subject to utilization review (see [Utilization Review Programs](#) on page 19).

Covered Outpatient Hospital services include:

- Radiation therapy;
- Chemotherapy (Experimental Chemotherapy is not covered);
- Electroconvulsive therapy; and
- Renal dialysis treatments received at a Hospital, or a dialysis facility, or at home under the supervision of a Hospital or dialysis facility.

Human Organ Transplants

Your benefits for eligible human organ and tissue transplants are the same as your benefits for any other condition. The transplants that the Plan covers are:

- Bone marrow;
- Cornea;
- Heart, lung and heart/lung;
- Heart valve;
- Kidney, pancreas and pancreas/kidney;
- Liver;
- Muscular-skeletal; and
- Parathyroid.

Transplants considered by the Medical Benefits Administrator to be Experimental or Investigational are not covered by the Plan. Transplants, as well as all other types of surgery, require utilization review in order to receive full Plan benefits (see [Utilization Review Programs](#) on page 19). Benefits are available to both the recipient and donor of a covered transplant under the following guidelines:

- If both the donor and recipient have medical coverage, each will receive benefits from his or her own medical plan.
- If you or a covered dependent is the recipient of a transplant, and the donor has no coverage from any other source, the Plan will provide benefits for both the recipient and the donor. Payments made for the donor will be charged against the recipient's Plan benefits.
- If you are the donor for the transplant and no coverage is available to you from any other source, the Plan will provide benefits to you. No benefits will be provided for the recipient.

The Plan will provide benefits for Covered Services related to the transplant surgery, including: the evaluation, preparation and delivery of the donor organ; the removal of the organ from the donor; and transportation of the donor organ within the United States and Canada.

If your Physician recommends a transplant, you must contact the Medical Benefits Administrator before your transplant surgery is scheduled. Then, when surgery is scheduled, you must contact the Medical Benefits Administrator again (see [Utilization Review Programs](#) on page 19). In addition to the other exclusions of this Plan, benefits will not be provided for the following services:

- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant surgery;
- Drugs which do not have approval of the Food and Drug Administration and are Experimental or Investigational;
- Travel time and related expenses required by a Provider;
- Storage fees; and
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.

Maternity Care

Notification to the Medical Benefits Administrator is required and must be made within the first trimester of pregnancy and again within two business days after an Inpatient Hospital admission related to pregnancy (see [Utilization Review Programs](#) on page 19).

Covered expenses for pregnancy are generally paid on the same basis as covered expenses for any other condition. Benefits will be provided for Covered Services rendered by a Physician or certified nurse-midwife. Benefits for expenses incurred for a normal pregnancy as well as medical complications during pregnancy also are covered.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, your Provider will not be required to obtain authorization from the Medical Benefits Administrator for prescribing a length of stay not in excess of 48 hours (or 96 hours). The Medical Benefits Administrator must be consulted for Hospital stays beyond the minimum requirement (see [Length of Stay Review](#) on page 20).

Mental Health Treatment

The Plan provides benefits for mental health treatment provided by a Physician, a Psychologist, clinical social worker, clinical professional counselor, or marriage and family therapist (or similarly licensed and credentialed counselor, as determined by the Medical Benefits Administrator) working within the scope of their license. The care may be provided on an Inpatient or Outpatient basis, or in an office setting. Contact the Medical Benefits Administrator for the criteria used to make a Medical Necessity determination under the Plan. Inpatient benefits are subject to utilization review (see [Utilization Review Programs](#) on page 19).

Newborn Care

The Plan covers certain services for newborns, including:

- Routine Inpatient Hospital nursery charges during the covered portion of the mother's normal Hospital stay; and
- One routine Inpatient exam by a Physician (other than the Physician who delivered the Child or administered anesthesia during delivery).

If the newborn requires treatment for an illness or injury, benefits will be paid only if you add the newborn to your Plan coverage. **To cover a newborn Child from birth, you must notify the ITW Benefits Service Center within 31 days of the Child's birth. If you miss this window, you will have to wait until a subsequent qualified change in status or the next open enrollment to add your newborn to coverage.**

Occupational Therapy

The Plan covers services rendered by a Physician or registered Occupational Therapist under the supervision of a Physician, which consists of a constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and

adapted to develop a physical function or to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur. Benefits are subject to the limitations noted in the [Summary of Benefits](#) starting on page 14. **Advance approval is not required; however, it is highly recommended before any therapy services are provided.**

Oral Surgery

Covered oral surgeries include:

- Surgical removal of complete bone impacted teeth;
- Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- Surgical removal of cysts or tumors on the roof or floor of the mouth, cheeks, jaws, lips or tongue;
- Treatment of fractures of facial bones;
- External incision and drainage of cellulitis;
- Surgical removal of exostoses of the jaws and hard palate, if the procedure is not done in preparation for dentures or other prostheses;
- Incision of accessory sinuses, salivary glands or ducts; and
- Reduction, dislocation or excision of temporomandibular joints (TMJ), excludes splints and appliances.

Outpatient Diagnostic Tests

The Plan covers Diagnostic Tests and lab services, including pre-admission tests that are done on an Outpatient basis. Diagnostic Tests are those that identify or evaluate a specific condition, disease or injury, which is suggested by the patient's symptoms.

Examples of Diagnostic Tests include:

- Allergy tests;
- MRIs, PET scans and CT or CAT scans;
- Diagnostic x-rays;
- Clinical lab tests and pulmonary function studies; and
- Electrocardiograms (EKGs), electroencephalograms (EEGs), radioisotope tests, and electromyograms (EMGs).

While sophisticated and expensive diagnostic procedures such as MRIs, PET scans and CT or CAT scans represent the leading edge in medical care diagnostic tools, these procedures may not be considered Medically Necessary, or there may be an equally effective (but lower cost) test available.

If a high-cost test is not determined to be Medically Necessary, its cost will not be covered by the Plan. Therefore, if your doctor orders a diagnostic procedure for you or a covered family member, you and/or your doctor are encouraged to obtain advance authorization from the Medical Benefits Administrator.

To obtain advance authorization (also known as pre-determination) – and avoid incurring the cost of expensive procedures that you will have to pay out of your own pocket – contact the Medical Benefits Administrator. When you call, be prepared to provide the following information:

- Name and subscriber number;

- Type of requested service;
- Diagnosis; and
- Planned date of service.

Additional medical information, including medical records, may be requested to determine whether or not the test is Medically Necessary.

Outpatient Surgery

Covered Outpatient Surgery services include physician fees, and ancillary services (such as operating rooms, drugs, surgical dressings, and lab work).

Physical Therapy

The Plan covers services rendered by a Physician or registered professional Physical Therapist under the supervision of a Physician, which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function or to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur. Benefits are subject to the limitations noted in the [Summary of Benefits](#) starting on page 14. **Advance approval is not required; however, it is highly recommended before any therapy services are provided.**

Physician Services

The Plan covers services of Health Professionals when you or your covered dependents:

- Require Inpatient care in a Hospital, Substance Abuse Treatment Facility, or Skilled Nursing Facility;
- Require Outpatient care;
- Visit the Health Professional's office; or
- Require the consultation of a specialist for the diagnosis or treatment of a condition.

The Plan also will provide benefits for consultations that are requested by your Physician. To be covered, consultations must be given by another Physician in the course of treating or diagnosing a condition, which requires special skill or knowledge.

Benefits are not available for any consultation done because of Hospital regulations or when the consulting Physician also performs surgery or maternity-related services during the same admission.

Preventive Care Services

The Plan covers preventive care services provided on an outpatient basis at a Physician's office or a Hospital that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease and have been proven to have a beneficial effect on health outcomes. Examples include routine lab tests, routine physical exams and routine x-rays.

The Plan covers the following preventive care items in accordance with federal law:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;

- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care and screenings for infants, children and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Such additional preventive care and screenings for women as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (and only when such requirements are effective).

For a detailed list of these covered services, contact the Medical Benefits Administrator or go to <http://www.healthcare.gov/law/about/provisions/services/lists.html>.

Private Duty Nursing

Benefits for private duty nursing care in your home will be paid only if these services cannot be provided by non-professional personnel. The Plan will not provide benefits if a nurse normally lives in your home or is a member of your immediate family. Private duty nursing includes teaching and monitoring of complex care skills and medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for private duty nursing services will not be provided due to the lack of willing or available non-professional personnel. The monthly maximum benefit for private duty nursing is stated in the [Summary of Benefits](#) starting on page 14.

Benefits for private duty nursing services are subject to utilization review (see [Utilization Review Programs](#) on page 19).

Skilled Nursing Facility

Benefits are available if you or a covered dependent are admitted, because it is Medically Necessary and at the direction of a Physician, to a Skilled Nursing Facility. Covered Services include bed and board, general nursing care, and other services (such as drugs and surgical dressings or supplies).

No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care. Benefits are subject to utilization review (see [Utilization Review Programs](#) on page 19).

Speech Therapy

The Plan covers services rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association for the correction of a speech impairment resulting from disease, including pervasive developmental disorders, trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Benefits for Inpatient Speech Therapy will be provided only if Speech Therapy is not the only reason for admission.

Speech Therapy does not include educational training or services designed and adapted to develop a physical function or to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur. Benefits are subject to the limitations noted in the [Summary of Benefits](#) starting on page 14. **Advance approval is not required; however, it is highly recommended before any therapy services are provided.**

Substance Abuse Treatment

The Plan provides benefits for treating Substance Abuse through an organized intensive, structured rehabilitative treatment program provided by either a Hospital or a Substance Abuse Treatment Facility and licensed by the appropriate State and local authorities to provide such service. The program may be either an Inpatient or Outpatient program or, if approved by the Medical Benefits Administrator, a partial hospitalization program (meaning you would spend either days or nights, but not both, in a facility).

Covered services do not include:

- Programs consisting primarily of counseling by individuals other than a Physician or Psychologist;
- Court-ordered evaluations;
- Programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities;
- Care in place of detention in a correction facility;
- Family retreats; or
- Treatment at a halfway house, boarding house, or other facility that primarily provides a supportive environment, even if counseling is provided in such facilities.

Inpatient benefits are subject to utilization review (see [Utilization Review Programs](#) on page 19).

Surgical Services

The Plan covers surgery performed by a Physician. The Plan also covers:

- Sterilization procedures – but not reversal of sterilization;
- Anesthesia given by a Physician other than the operating surgeon, including a Certified Registered Nurse Anesthesiologist (CRNA);
- Services of a Physician who assists the operating surgeon in performing surgery – in addition, benefits will be provided for assist at surgery when performed by a registered surgical assistant or an advanced practice nurse or by a physician assistant under the direct supervision of a Physician; and
- All stages of reconstruction of the breast following a mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance, breast prostheses, and treatment of physical complications at all stages of mastectomy (including lymphedemas).

Vision Services

Plan covers annual eye exam and refraction as part of Adult/Child Wellness Care. A discount program is available for glasses and contact lenses. For details, contact the Medical Benefits Administrator.

Miscellaneous Other Covered Services

The Plan also provides benefits for:

- Blood and blood components;
- Leg, back, arm, and neck braces;
- Orthotics;
- Dental services due to an accidental injury;

- Cardiac rehabilitation services started within 90 days of the cardiac event such as a heart attack, coronary bypass, angioplasty, transplant or other events as approved by the Medical Benefits Administrator – benefits include up to three sessions per week for up to a twelve week period (36 sessions);
- Diabetic self-management training services;
- Oxygen and its administration;
- Medical and surgical dressings, supplies, casts and splints; and
- Prosthetic devices, special appliances and surgical implants needed to replace all or part of an organ or tissue, or to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

What the ITW Medical Plan Does Not Cover

The following is a list of most of the services that are not covered by the ITW Medical Plan. To determine if a service or supply is covered by the Plan, contact the Medical Benefits Administrator.

- Hospitalization, services and supplies that are not Medically Necessary – as determined by the Medical Benefits Administrator;
- Services or supplies received before the patient was covered under the Plan;
- Charges that exceed the Eligible Charge or Maximum Allowance;
- Services or supplies received after applicable annual maximum benefits have been paid;
- Treatment not prescribed or recommended by a Physician or other Health Professional acting within the scope of his or her license;
- Educational, vocational or training services and supplies (except where noted);
- Services or supplies for an illness or injury that is covered under workers' compensation or similar laws whether or not you make a claim for compensation or receive benefits;
- Services or supplies which are provided by any government program or law, or services or supplies for which payment is provided or available from any government program or law – for example, Medicare – whether or not payment is received;
- Services and supplies for any illness or injury occurring on or after the date coverage takes effect as a result of war or act of war;
- Services or supplies that do not meet accepted standards of medical and/or dental practice;
- Experimental or Investigational services and supplies as determined by the Medical Benefits Administrator – unless you are participating in a qualified clinical trial and those services or supplies would otherwise be covered if not provided in connection with a qualified clinical trial program;
- Transportation, local ambulance service, or air ambulance service, when not Medically Necessary as determined by the Medical Benefits Administrator;
- Consultation done because of Hospital regulations or when the consulting Physician also performs surgery or maternity-related services during the same admission;
- Custodial Care services;
- Long term care services;
- Respite care services – except as specifically covered under Hospice care;
- Inpatient private duty nursing;

- Services or supplies received during an Inpatient stay when the stay is primarily for a behavioral problem, social maladjustment, lack of discipline or other antisocial actions;
- Cosmetic surgery and related services and supplies – unless performed to correct congenital deformities or for conditions resulting from accidental injuries, scars, tumors or disease;
- Services or supplies for which you are not required to make a payment or for which you otherwise would not have to pay;
- Charges for failure to keep a scheduled appointment, completion of a claim form, preparing medical reports or itemized bills;
- Personal hygiene, and comfort and convenience items that are not Medically Necessary – such as air conditioners, humidifiers, physical fitness equipment, and devices to adjust vehicles for a Disabled passenger/driver, such as wheelchair lifts;
- Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants – except as specifically mentioned in this summary;
- Expenses related to removal of breast or other prosthetic implants, if originally inserted in connection with cosmetic surgery – removal of breast or other prosthetic implant is covered if medically necessary;
- Blood derivatives which are not classified as drugs in the official formularies;
- Eyeglasses, contact lenses or cataract lenses (the first lens after a cataract surgery is covered) and the prescribing or fitting of glasses or contact lenses – contact the Medical Benefits Administrator for a discount program on glasses and contact lenses;
- Routine foot care, except for persons diagnosed with diabetes;
- Treatment and prescription of supportive devices for flat foot conditions and the treatment of subluxations of the foot;
- Maintenance Occupational, Physical and Speech Therapy administered to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur;
- Maintenance care;
- Applied Behavioral Analysis;
- Speech therapy – when rendered for treatment of psychological speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation;
- Hearing aids or exams for their prescription or fitting – except as specified in Adult/Child Wellness Care (contact the Medical Benefits Administrator for a discount program on hearing aids);
- Services and supplies to the extent benefits are duplicated because the Spouse (or Domestic Partner), parent and/or child are covered separately under the Plan;
- Services or supplies furnished by members of your immediate family, including parents, parents-in-law, Spouse, siblings and children;
- Surveys, case findings, research studies, screening or similar procedures and studies, or tests which are Experimental or Investigational – unless otherwise specified in this summary;
- Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient or unrelated to the treatment of a disease or injury;
- Wigs (also referred to as cranial prostheses);

- Services and supplies rendered or provided for human organ or tissue transplants – unless otherwise specified in this summary;
- Reversal of sterilizations;
- Services and supplies rendered or provided for the diagnosis and/or treatment of infertility – including (but not limited to) Hospital services, medical care, therapeutic injections, fertility and other drugs, surgery, artificial insemination and all forms of in vitro fertilization;
- Sex change surgery, including related services and supplies;
- Corrective eye surgery to decrease or eliminate dependency on glasses or contact lenses such as radial keratotomy or Lasik eye surgery;
- Drugs that can be purchased over the counter;
- Splints and appliances rendered or provided for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and related disorders;
- Services and supplies received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union or similar person or group;
- Harvesting charges for donor organs not covered when recipient is covered by another plan.
- Smoking cessation programs – refer to the *Managed Prescription Drug Program* (see below);
- Weight loss programs or health club memberships – contact the Medical Benefits Administrator for available discount programs;
- Massage therapy by a massage therapist;
- Alternative medicines including such things as acupuncture and hypnosis therapy. Contact the Medical Benefits Administrator for available discount programs
- Services provided by a Christian Science practitioner;
- Any services or supplies not listed in [What the ITW Medical Plan Covers](#) starting on page 20; and
- Outpatient prescription drugs except as provided in *Managed Prescription Drug Program* (see below).

Managed Prescription Drug Program

Prescription drug benefits under the Plan are provided through the Managed Prescription Drug Program (the Program). Prescriptions are filled either through a retail network pharmacy (for acute or short-term prescriptions) or the mail order pharmacy (for maintenance or long-term medications).

The Plan generally covers medications prescribed by a Physician in the course of treating a covered Illness or Injury. Some medications may require a closer review by the Pharmacy Benefits Administrator (see [Prescription Drug Limitations](#) on page 33). This is true for existing medications and for new medications as they are developed and prescribed. Prescription drugs under the Program are subject to all the other Plan exclusions (see [What the ITW Medical Plan Does Not Cover](#) starting on page 29), including those related to Experimental or Investigational treatments and Medically Necessary standards.

What the Program Covers

Examples of prescription medications that are generally covered by the Program include:

- Outpatient federal legend drugs – any drug product which bears the legend “Caution Federal Law prohibits dispensing without a prescription”;
- Injectable insulin;
- Diabetic supplies and insulin delivery devices – including disposable needles and syringes, test strips, lancets, glucometers and blood glucose monitoring machines;
- Oral and injectable contraceptives prescribed by a doctor; and
- Smoking deterrents.

To encourage tobacco-free campuses across ITW, the Plan pays the full cost of generic tobacco cessation prescription drugs and the brand-name product Chantix (see *Prescription Drug Program Benefits* on page 18).

What the Program Does Not Cover

Not all medications are covered by the Program, including:

- Legend vitamins – except prenatal vitamins;
- Fertility drugs;
- Experimental or Investigational drugs;
- Dental products;
- Drugs that are FDA approved for cosmetic use only;
- Implantable insulin pumps or needle-free injection systems;
- Raw bulk chemicals;
- Contraceptive devices, appliances and implants – treated as covered medical services;
- Retin-A – if over age 23;
- Nutritional supplements;
- Rogaine or similar products; and
- Over-the-counter products or equivalents and state restricted drugs.

To find out whether a particular medication is covered, contact the Pharmacy Benefits Administrator at 888.437.4926 or visit its website at www.caremark.com.

Retail Network Pharmacy

The Pharmacy Benefits Administrator has contracted with various local and national pharmacies, called network pharmacies, to provide you with prescription drugs at a reduced rate. Through a retail network pharmacy you may obtain up to a 30-day supply for short-term medications, such as antibiotics.

To use a retail network pharmacy, take your prescription to any network pharmacy and present your prescription drug identification card to the pharmacist along with your prescription. To identify a network pharmacy, you should call the Pharmacy Benefits Administrator at **888.437.4926** or visit its website at www.caremark.com. If you use a non-network pharmacy, contact the Pharmacy Benefits Administrator to see if any of your costs will be reimbursed under the Program.

Mandatory Mail

The Program requires that mail service be used for all maintenance medications; however, you may receive your original fill and one refill at your retail pharmacy prior to being required to use mail order. Medication for chronic conditions such as diabetes, arthritis, high blood pressure, high cholesterol, etc., or long term therapy are generally considered maintenance. In order to determine if a medication you are taking is categorized as a maintenance medication, call the Pharmacy Benefits Administrator at **888.437.4926** or visit its website at www.caremark.com.

Mail Order Pharmacy

Your Physician may write a prescription for up to a 90-day supply with refills for up to one year when you use the mail order pharmacy. To use mail order, request the appropriate form from the Pharmacy Benefits Administrator at **888.437.4926** or visit its website at www.caremark.com. For refills, you may use the mail order refill form supplied to you with your original order, call the Pharmacy Benefits Administrator or visit its website. Be prepared to give your member number, prescription number and your payment information.

Specialty Pharmacy

The Specialty Pharmacy delivers Specialty Medications directly to member's home and/or doctor's office. Specialty Medications include oral medications as well as injectable and infused therapies used to treat complex medical conditions such as growth hormone deficiency, hepatitis C, immune deficiency, hemophilia, multiple sclerosis and rheumatoid arthritis.

Specially trained Pharmacy Services Representatives are available Monday – Friday from 8:00 a.m. to 8:00 p.m. CT and Saturday from 9:00 a.m. to 1:00 p.m. CT. They will help you manage your prescription therapy by encouraging you to take your medication as prescribed, managing any medication side effects, counseling you on your health condition, and coordinating new and refill prescriptions.

Specialty Medications will be dispensed through the Pharmacy Benefits Administrator's Specialty Pharmacy, which is a mail order facility. Specialty Medications are filled up to a 30-day supply through the Specialty Pharmacy.

To obtain information on drugs dispensed through the Specialty Pharmacy, you should call Specialty Pharmacy Customer Care at **800.237.2767** or visit its website at www.caremark.com.

Prescription Drug Program Limitations

There are certain medications that require a closer review by the Pharmacy Benefits Administrator. Through the programs listed below, the Pharmacy Benefits Administrator will verify the appropriateness of prescriptions for certain medications before they will be covered under the Plan.

Prior Authorization (PA). Prior authorization means a Medical Necessity review is performed before the prescription is authorized. This Medical Necessity prior authorization requires a medical diagnosis from the prescribing doctor. Some medications require more information in addition to the medical diagnosis. Your

pharmacist may supply the Pharmacy Benefits Administrator with the necessary information (if it is provided on the actual prescription) or your doctor can call or fax the appropriate medical documentation to the Pharmacy Benefits Administrator. After receiving the information (from your doctor), pharmacists at the Pharmacy Benefits Administrator will determine if the condition falls within the appropriate medical guidelines based on current medical literature.

If you or your dependents are taking one of the medications subject to PA, you may wish to bring your Prescription Drug Program information with you the next time you visit your doctor. To avoid any delay in obtaining a medication that requires a medical diagnosis, you may wish to have your doctor contact the Pharmacy Benefits Administrator in advance of writing the prescription.

Quantity Limitation (QL). Quantity limitation establishes the maximum number of pills or units (for example, injections or nasal spray bottles) covered by the Plan within a specified time period, usually 30 days. The quantity limitations do not prevent you from purchasing more of the drug yourself.

Step Therapy Protocol (STP). Step therapy protocol is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other more aggressive therapies, only if necessary. For example, you may be asked to first try a generic before other medications are used. The step therapy protocol program does not prevent you from purchasing a drug yourself.

To obtain information on drugs that have prior authorization (PA), quantity limitation (QL) or step therapy protocol (STP) requirements, you should call the Pharmacy Benefits Administrator at **888.437.4926** or visit its website at www.caremark.com.

Nursing Home Override

An override can be placed on the mandatory mail requirement of the Program for any participant confined to a nursing home where the participant is unable to utilize the Program's mail order pharmacy. Contact the Pharmacy Benefits Administrator at the phone number listed in the Summary of Benefits for the required documentation to set up the override. If approved, the override will go into effect the date the required documentation is received by the Pharmacy Benefits Administrator. Past denied claims will not be adjusted.

No Coordination of Benefits

Benefits through the Prescription Drug Program are not coordinated with prescription benefits provided through other plans.

Limitations on Plan Benefits

Coordination of Benefits

Many individuals have medical coverage in addition to the Plan. If the Medical Benefits Administrator sends you a questionnaire regarding other insurance for your covered dependents, please respond promptly to ensure claims are processed without delay. The Plan works with other group plans to reimburse covered expenses for you or your dependents. The information that follows explains how the Plan's coordination of benefits (COB) provision works.

Which Plan Pays First

When a person is covered under two or more plans, one plan is primary and the other secondary. Plan benefits are coordinated with benefits provided under another plan, as follows:

- The primary plan pays its benefits first, without regard to any other plan; then
- The secondary plan will pay the difference between the amount it would have paid if it had been primary and the benefit amount paid by the other plan.

The Plan applies several rules in determining whether it or the other plan is primary. The other plan will always be primary if it lacks a provision for coordinating benefits. If the other plan has a coordinating provision, here is how the primary plan will be determined:

- The plan covering the individual directly, rather than as a dependent, will be the primary plan.
- If you are a retiree enrolled in more than one retiree medical plan, coverage under Medicare (if eligible) will be primary, then coverage under the retiree plan in effect for the longest will be secondary, and coverage under the other retiree plan will be tertiary or third.
- If a Child is covered under both this Plan and the other parent's plan, the Birthday Rule applies, meaning that the parent whose birthday comes first in the calendar year has the primary plan. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other parent's plan does not have a birthday type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.
- If you are separated, divorced, or never married and your Child is covered as a dependent both under this Plan and under another plan, the following rules will apply to determine which plan is primary (in the following sequence):
 - The plan of the parent whom the court has established as financially responsible for the Child's health care expenses;
 - The plan of the parent with custody of the Child;
 - The plan of the step-parent married to the parent with custody of the Child; or
 - The plan of the parent who does not have custody of the Child.
- When a determination cannot be made, the plan that has covered the Child longest will be considered primary.

The Plan will pay benefits first when it is primary. When the Plan is the secondary plan, the Plan will pay the difference between the amount it would have paid if it had been primary and the benefit amount paid by the other plan.

If You Are Eligible for Medicare

If you are a regular full-time active employee or a dependent of a regular full-time active employee, the Plan is primary and Medicare is secondary unless you receive kidney dialysis treatments in connection with end stage renal disease (ESRD). If you receive kidney dialysis treatments in connection with ESRD, this Plan will be the primary plan for the first 30 months of treatments, even if you are enrolled in Medicare. During this time Medicare is the secondary payor. After 30 months of treatments, Medicare will be your primary plan and this Plan will be the secondary plan. For more information on ESRD, you can call **800.MEDICARE**.

Important! If your Domestic Partner can get Medicare coverage due to his/her age and he/she is also covered under the Plan, Medicare will be primary.

If Medicare is primary, you must be enrolled in Medicare Parts A and B in order to receive full benefits from the Plan. If you choose not to enroll in Part B coverage, you will pay more in out-of-pocket expenses. Here's why: After your claim is filed with Medicare and then submitted to the ITW Medical Plan, the Plan will consider what Medicare would have paid if you had both Part A and Part B coverage, even if you don't have Part B coverage. If you don't have Part B coverage, you will pay those Part B charges out of your own pocket.

When is Medicare Primary?

If you are not a regular full-time active employee (for instance, you are Disabled, retired or on COBRA), Medicare Parts A and B will be your primary plan (provided you are eligible for Medicare) and the Plan will be your secondary plan. That means Medicare pays benefits first and determines the approved amount for services incurred. The Plan pays based on this Medicare-approved amount less Medicare Parts A and B benefits. However, if you enroll in a Medicare Part C (Medicare Advantage Plan) or Medicare Part D (Medicare Prescription Drug Plan), there will be no coordination of benefits with the ITW Medical Plan. If enrolled in a Medicare Part C or Medicare Part D plan you can no longer be enrolled in the ITW Medical Plan and will not be eligible to receive benefits under this Plan.

Reimbursement Provisions

If you or one of your covered dependents incurs expenses for a sickness or Injury that occurred due to the negligence of a third party and benefits are provided for Covered Services described in this SPD, you agree that:

- The Plan has the right to reimbursement for all benefits the Plan provided from the first dollars of any and all monies or funds collected from the third party (whether such reimbursement occurred due to an action at law, settlement, or compromise by you or your legal representative) as a result of action causing the sickness or injury, whether or not the proceeds are designated as payment for medical expenses and even if you are not made whole.
- The Plan is assigned the right to recover from the third party, or his or her insurer or representative, to the extent of the benefits the Plan provided for that sickness or injury. The Plan shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses for which the Plan has provided benefits as a result of that sickness or injury. You are required to generally cooperate with and furnish any information or assistance or provide any documents that the Medical Benefits Administrator (or Pharmacy Benefits Administrator) or their representatives or agents may reasonably require in order to obtain the rights of the Plan under this provision. You or your covered dependent(s) shall not take any action that prejudices the Plan's rights of reimbursement. This provision applies whether or not the third party admits liability.

This reimbursement shall be from any recovery made by you or your covered dependent, and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties. The Plan shall be responsible only for

those legal fees and expenses to which it agrees in writing. You or your covered dependent(s) shall not incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder. Specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the express written consent of the Plan. Any so-called Fund Doctrine or Common Fund Doctrine or Attorney's Fund Doctrine shall not defeat this right.

In cases of occupational illness or injury, the Plan's recovery rights shall apply to all sums recovered, regardless of whether the illness or injury is deemed compensable under any workers' compensation or other coverage.

Any award or compromise settlement, including any lump-sum settlement, shall be deemed to include the Plan's interest and the Plan shall be reimbursed in first priority from any such award or settlement.

The Plan shall recover the full amount of benefits advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary of covered person, whether under comparative negligence or otherwise.

Note: This reimbursement section is intended to prevent the application of two legal doctrines, the make whole rule and the common fund rule and similar rules. All references in this reimbursement section to you include your covered dependent(s), the guardian or estate of you and your covered dependent, the personal representative of such estate, your heirs and an attorney representing you or your covered dependents.

Subrogation/Third Party Reimbursement

If the Plan pays your medical benefits for a sickness or injury that was caused by an act or omission of a third party, the Plan has the right to be repaid for any such benefits from any recovery you receive from or on behalf of the third party – including any settlement, judgment or insurance proceeds – up to but not more than the aggregate amount received from or on behalf of each responsible party or third party.

You must either hold such amounts received in a trust or constructive trust for the Plan or repay the Plan on a first dollar basis (meaning that the Plan has a right to be repaid first from any monies you receive). The Plan has a right to be reimbursed whether or not the third party admitted liability for the payment, whether or not a portion of the recovery was identified as a reimbursement of medical expenses, and whether or not you are made whole by the recovery.

By accepting benefits under the Plan, you agree to provide the Plan with a lien, to the extent the Plan has paid medical benefits, to be filed with the responsible party or insurance company of the responsible party. The Plan is subrogated to all of your rights or your covered dependent(s)' rights against any party liable for the injury or illness, or is or may be liable for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the value of the medical benefits advanced to you or your covered dependent(s) under the Plan. The Plan may assert this right independently of the covered person. This right includes, but is not limited to, you or your covered dependent(s) rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, or other insurance. If you do not hold any recovery in trust or constructive trust or reimburse the Plan from any recovery you have obtained from a third party or another entity as a result of your injury or illness, the Plan may reduce any benefits for current or future medical expense benefits payable to you or payable on your behalf until the Plan has been fully reimbursed. The Plan is not obligated in any way to pursue this right independently on you or your covered dependent(s)' behalf, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

If benefits are provided under this section, you will be required to cooperate with the Plan and its representatives or agents promptly to protect the legal rights of the Plan, including compliance with the terms of this section, providing any relevant information requested, signing or delivering requested documents, and appearing at medical examinations and legal proceedings. If you or your covered dependent(s) enters into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, the subrogation rights of the Plan under this section. In the event that you or your covered dependent(s) fail to cooperate with this provision, including executing any documents required herein, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan. You may not accept any settlement that does not fully reimburse the Plan as provided in this section, without the written approval of the Plan.

Overpayment

If you or a dependent receive benefits that were paid in error, you will be required to reimburse the Plan the full amount of the overpayment immediately. If payment is not received upon notification of overpayment from the Medical Benefits Administrator or the Pharmacy Benefits Administrator, the amount you owe the Plan will be deducted from future benefit payments.

Filing Claims

How to File a Claim

To file a claim, show your health care identification card to the Hospital or Health Professional when you receive services.

In most cases, the Hospital or Health Professional will file the claim with the Medical Benefits Administrator.

In certain situations, you must file a claim directly with the Medical Benefits Administrator according to the following procedure:

- Complete a claim form, which is available at www.bcbsil.com/itw or by calling **800.325.0320**.
- Attach copies of all bills to be considered for benefits. The bills must include:
 - The health care Provider's name and address;
 - The patient's name;
 - The diagnosis;
 - The date and description of the service;
 - The amount of the charge; and
 - Any other information requested on the claim form.
- Mail the completed claim form, with all bills attached, to the Medical Benefits Administrator at the address on the claim form.

Claims must be submitted for processing within 24 months of the date(s) services are received. Claims not submitted within this period will not be eligible for payment.

Pre-authorization Review for Pharmacy Benefits

For certain prescription drug benefits, the Pharmacy Benefits Administrator will implement the **prescription drug cost containment program** by comparing requests for certain medicines and/or other prescription benefits against pre-defined medical criteria specifically related to use of those medicines or prescription benefits before those prescriptions are filled. In many cases, your physician or pharmacy provider will submit this pre-authorization review of your claim (see [Prior Authorization \(PA\)](#) on page 33).

Medicare Crossover

In most states, the Medical Benefits Administrator has systems in place to automatically receive information directly from Medicare for both Medicare participating and non-participating Providers. The process works as follows: Medicare sends electronic information from Medicare claims to the Medical Benefits Administrator, then the Medical Benefits Administrator may begin to process the claim as a secondary payor. You may call the Medical Benefits Administrator to find out whether Medicare Crossover is available for your area.

There is no coordination of benefits between Medicare Part C (Medicare Advantage Plan) or Medicare Part D (Medicare Prescription Drug Plan) and the ITW Medical Plan. If you enroll in a Medicare Part C (Medicare Advantage Plan) or Medicare Part D (Medicare Prescription Drug Plan), you can no longer be enrolled in the ITW Medical Plan and will not be eligible to receive benefits under this Plan.

Medicare Claims

If you are eligible for Medicare and Medicare is the primary coverage (see [If You Are Eligible for Medicare](#) on page 35), the procedure to file your claims is slightly different, as explained below:

For Hospital Bills:

Step 1: The Hospital will bill Medicare directly.

Step 2: The Hospital will bill you for any unpaid portion. Once you receive a notice indicating what Medicare has paid, send the following to the Medical Benefits Administrator at the address shown on the claim form:

- A completed claim form;
- The itemized Hospital bill; and
- A copy of Medicare's explanation of benefits.

Note: If Medicare Crossover is available in your area, you may not need to complete Step 2.

For Non-Hospital Bills:

Step 1: Submit the bills to Medicare first. Be sure to keep a copy of the bills you send.

Step 2: Once you receive a notice indicating what Medicare has paid, send the following to the Medical Benefits Administrator for processing:

- A completed claim form;
- The itemized bill; and
- A copy of Medicare's explanation of benefits.

If Medicare Crossover is available in your area, you may not need to complete Step 2.

Remember, if Medicare is primary, you must be enrolled in Medicare Parts A and B in order to receive full benefits from the Plan. If you choose not to enroll in Part B coverage, you will pay more in out-of-pocket expenses. Here's why: After your claim is filed with Medicare and then submitted to the ITW Medical Plan, the Plan will consider what Medicare would have paid if you had both Part A and Part B coverage, even if you don't have Part B coverage. If you don't have Part B coverage, you will pay those Part B charges out of your own pocket.

Where to Get Claim Forms

To request claim forms, contact the Medical Benefits Administrator or visit the Medical Benefits Administrator's website.

Payment of Claims and Assignment of Benefits

Under this Plan, the Medical Benefits Administrator (or Pharmacy Benefits Administrator, if applicable) has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Medical Benefits Administrator may pay benefits to you if you receive Covered Services from a Non-PPO Provider. The Medical Benefits Administrator is specifically authorized by you to determine to whom any benefit payment should be made.

Once a Provider renders Covered Services, you have no right to request the Medical Benefits Administrator (or Pharmacy Benefits Administrator, if applicable) not to pay the claim submitted by such Provider and no such request will be given effect. In addition, the Medical Benefits Administrator (or Pharmacy Benefits Administrator, if applicable) will have no liability to you or any other person because of its rejection of such request.

Your claim for benefits under this Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to you. Coverage under this Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

Claims Review Process

If you submit a claim for benefits, and the claim is fully or partially denied, the procedures described below will apply. For medical, mental health and substance abuse claims, contact the Medical Benefits Administrator. For prescription drug claims, contact the Pharmacy Benefits Administrator. In addition, see [Prescription Drug Benefit Claims](#) on page 43 for special rules and procedures that apply solely to prescription drug benefits.

Initial Review of Claims

The Plan makes a distinction between pre-service claims and post-service claims. The most common claims are post-service claims where services have already been rendered or received. Less common are pre-service claims

where you are required to obtain approval before obtaining care such as inpatient hospitalization or inpatient mental health or substance abuse treatment or Prior Authorization or Step Therapy Protocol programs for prescription drug benefits.

The Benefits Administrator will review your claim and notify you of its decision to approve or deny your claim. The notification will include information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and the diagnosis and treatment codes (and their corresponding meanings). Such notification will be provided to you in writing within a 30-day period from the date you submitted your post-service claim and 15 days for pre-service claims, except for situations requiring an extension of time of up to 15 days because of matters beyond the control of the Plan.

If the Benefits Administrator needs such an extension, the Benefits Administrator will notify you prior to the expiration of the initial 30 or 15-day period in writing, state the reason why the extension is needed, and state when it will make its determination. For pre-service claims, if an extension is needed because you did not provide sufficient information or filed an incomplete claim, the Benefits Administrator will notify you within five days to request the missing information.

The time from the date of the Benefits Administrator's notice requesting further information and an extension until the Benefits Administrator receives the requested information does not count toward the time period the Benefits Administrator is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the notice requesting further information from the Benefits Administrator.

Denial of Claims

If the Benefits Administrator denies your claim in whole or in part (referred to as an adverse benefit determination), you will be provided notification of the claims decision, which will be written in a manner calculated to be easy for you to understand.

This notice will:

- State the reason why your claim was denied;
- Cite the specific Plan provision(s) on which the denial is based;
- Describe any additional information necessary to perfect the claim and explain why such information is necessary;
- Describe the Plan's review procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA within 180 days of receiving a notice of denial on appeal; and
- Include the denial code and its corresponding meaning as well as describe the Benefits Administrator's standard, if any, used in making the benefit determination.

Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the adverse benefit determination (that is, the denial of your claim in whole or in part), the notice of adverse benefit determination will state the rule, protocol, guideline or other criterion or indicate that such rule, protocol, guideline or other criterion was relied upon and will state that you may request a copy free of charge. If the decision was based on medical necessity, experimental treatment or similar exclusion, either an explanation of such exclusion applying the terms of the Plan to the medical circumstances will be provided or a statement that you may request an explanation of such exclusion free of charge.

Adverse benefit determinations include cases where Plan coverage is terminated retroactively (other than in cases of fraud or misrepresentation or terminations due to failure to timely pay premiums). These retroactive terminations are called rescissions of coverage under federal law.

If written notice of the Benefits Administrator's decision is not provided within 30 days (15 days for pre-service claims) or 45 days in the event of an extension (30 days for pre-service claims) after the Benefits Administrator receives the claim, the claim is considered to be denied and you may make an appeal of the denial.

Appeal of Denied Claims

If the Benefits Administrator denies your claim in whole or in part, you may make an appeal of the initial determination. Upon your written request, the Benefits Administrator will provide you free of charge with copies of documents, records and other information relevant to your claim. Your coverage will continue while your claim is pending. You must submit your appeal to the appropriate Benefits Administrator at the address indicated within 180 days of receiving the Benefits Administrator's adverse benefit determination. Appeals must be in writing and must include at least the following information:

- Name of Employee;
- Name of the Plan;
- Reference to the initial determination;
- An explanation why you are appealing the initial determination; and
- Any clinical documentation from your physician that would substantiate coverage of the adverse benefit determination.

As part of the appeal, you may submit any written comments, documents, records, or other information relating to your claim and you may also provide testimony.

After the Benefits Administrator receives your written request appealing the initial adverse benefit determination, the Benefits Administrator will conduct a full and fair review of your claim.

Deference will not be given to the initial determination, and the Benefits Administrator's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial determination is based in whole or in part on a medical judgment, the Benefits Administrator will consult with a health care professional with appropriate training and experience in the field of medicine involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination. Upon your written request, the Benefits Administrator will identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the determination.

If any new or additional evidence (i.e., evidence that wasn't part of the initial determination) is relied upon or generated by or at the direction of the Benefits Administrator during the appeal, the Benefits Administrator will provide you with such evidence early enough to give you a reasonable chance to respond before the deadline below for a final determination.

Similarly, if the Benefits Administrator determines that there is a new rationale for denying a claim that was not part of the initial determination, the Benefits Administrator will provide you with that rationale in enough time to give you a reasonable chance to respond before the deadline for a final determination.

The Benefits Administrator will notify you in writing of its final decision. The notification will identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement on the availability of the diagnosis and treatment codes and their corresponding meanings. The notification will be provided within 60 days after the Benefits Administrator's receipt of your written request for review of a post-service claim and within 30 days for a pre-service claim. If you do not receive notice within these time periods, your claim is considered to be denied.

If the Benefits Administrator denies the claim on appeal, the Benefits Administrator will send you a final written notification of the adverse benefit determination (that is, the denial of your claim in whole or in part), which will be written in a manner calculated to be easy for you to understand, that states the reason(s) why the adverse benefit determination you appealed is being upheld, that includes a discussion for the decision, and that references any specific Plan provision(s) on which the determination is based. The notice will include:

- The denial code, and its corresponding meaning, as well as a description of the Benefit Administrator's standard, if any, that was used in denying your claim;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
- A statement describing the Plan's review procedures and a statement of your right to bring a civil action under section 502(a) of ERISA within 180 days of receiving a notice of denial on appeal.

If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final notification will state the rule, protocol, guideline or other criterion or indicate that such rule, protocol, guideline or other criterion was relied upon and that you may request a copy free of charge. If the determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the notification will include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. When the claim has been processed, you will be notified of the benefits paid. If any benefits have been denied, you will receive a written explanation.

This Claims Review Process under the Plan is designed to ensure that the Benefits Administrator making these determinations is independent and impartial. To that end, no hiring, compensation or other decisions are based on the likelihood of the Benefit Administrator upholding an adverse benefit determination.

Prescription Drug Benefit Claims

Claims for prescription drug benefits have certain special rules and procedures. Where there is a difference between this Prescription Drug Benefit Claims section and any other provisions in the SPD, the procedures discussed in this Prescription Drug Benefit Claims section shall apply.

Prescription drug benefit claims are reviewed under a two-level process. Under the first-level of review, the Pharmacy Benefits Administrator will take into account all comments, documents, records and other information you submit relating to the claim, without regard to whether such information was submitted or considered in the

initial benefit determination on the claim; follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Plan documents; follow reasonable procedures to ensure that the applicable Plan provisions are applied to you in a manner consistent with how such provisions have been applied to other similarly-situated Plan participants; and provide a review that does not afford deference to the initial adverse benefit determination and is conducted by an individual other than the individual who made the initial adverse benefit determination (or a subordinate of such individual). This first-level review will not analyze whether the benefits you claim are Medically Necessary.

You can request an additional second-level review for any denial (including a review if the benefits you claim are Medically Necessary). The review will be performed by an Independent Review Organization who will consult with an appropriate health care professional who was not consulted in connection with the initial adverse benefit determination (nor a subordinate of such individual); identify the health care professional, if any, whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination; and provide for an expedited review process for Urgent Care Claims.

Urgent Care Claim Submission

A small number of claims for medical benefits may be urgent care claims. Urgent care claims are those where failing to make a determination quickly could seriously jeopardize your life, health, or ability to regain maximum function, or could subject you to severe pain that could not be managed without the requested treatment. Any claim that a physician (with knowledge of a claimant's condition) considers an urgent care claim is an urgent care claim under these rules.

Your doctor may submit such a claim to the Benefits Administrator by telephoning the Benefits Administrator and informing the Benefits Administrator that the claim is an Urgent Care Claim.

Urgent Care Claims are processed according to the procedures set out above, however once a claim for urgent care is submitted, the Benefits Administrator will notify you of the determination on the claim as soon as possible, but no later than 72 hours after the claim was filed.

If your claim for urgent care is denied in whole or in part, the notice you receive will contain all of the standard information for denials and will also describe the expedited review procedures for urgent care claims. The notice may also be given orally, in which case you would receive a written or electronic notice within 3 days after the oral notice. If you or your covered dependent do not provide the Benefits Administrator with enough information to decide the claim, the Benefits Administrator will notify you within 24 hours after it receives the claim of the further information that is needed. You will have 48 hours to provide the information.

- If the needed information is provided, the Benefits Administrator will then notify you of the claim decision within 48 hours after the Benefits Administrator received the information.
- If the needed information is not provided, the Benefits Administrator will notify you or your covered dependent of its decision within 120 hours after the claim was received.

If your urgent care claim is denied but you receive the care, you may appeal the determination using the normal claim procedures. If your urgent care claim is denied and you do not receive the care, you can request an expedited appeal of your determination by phone or in writing. The Benefits Administrator will then notify you of its

decision in writing within 72 hours of your request. However, the Benefits Administrator may notify you by phone within the time frames above and then send you a written notice.

External Review

If you receive an adverse benefit determination from the Benefits Administrator, you may file a request to have your claim reviewed through the external review process. Your request must be filed with the Benefits Administrator within 125 days after the date you received notice of the adverse benefit determination.

Within five business days after it receives your request for external review, the Benefits Administrator will complete a preliminary review of your request. As part of the preliminary review, the Benefits Administrator will determine whether:

- You were covered by the Plan at the time your claim was incurred;
- The adverse benefit determination is related to your eligibility to participate in the Plan;
- You have exhausted the internal appeals processes listed above; and
- You have provided all information and forms required to process an external review.

Within one business day of completing the preliminary review, the Benefits Administrator will issue you a written notification as follows:

- If your request for external review is complete but not eligible for external review, the notice will explain why your request is ineligible for external review and provide you with contact information for the Employee Benefits Security Administration.
- If the request is not complete, the notice will describe the information or materials needed to make the request complete. You will have the remainder of your four-month request period or 48 hours (whichever is later) to submit the necessary information to perfect your request.

Otherwise, if your request is complete and eligible for external review, the Benefits Administrator will assign your claim to an accredited Independent Review Organization (IRO). You should know that these organizations receive no financial benefits from the Plan for denying claims.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. This notice will inform you that you have 10 business days to submit additional written information to the IRO for the IRO to consider when reviewing your claim. The IRO is not required to accept and/or consider additional information submitted after the expiration of the ten-day submission period, but may, in its discretion, elect to consider it.

Within five business days after your claim is assigned to an IRO, the Benefits Administrator is required to provide to the IRO the documents and any information considered in making the determination for which you are seeking review. Should the Benefits Administrator fail to timely provide the documents and information, the IRO may terminate its external review and simply reverse the prior adverse benefits determination. In such a case, the IRO would notify you and the Benefits Administrator within one business day.

After receiving any information submitted by you, the IRO will within one business day forward the information to the Benefits Administrator – which may then reconsider its earlier benefit determination. (If the Benefits

Administrator decides to reverse the earlier adverse determination, it will notify you and the IRO within one business day. At that point, the IRO would stop its external review.)

The IRO will review all of the timely submitted information and documents that it receives. In reaching its decision, the IRO will review the claim without regard to the Benefits Administrator's decision. In other words, the IRO will not be bound by any decisions or conclusions reached by the Benefits Administrator. In addition to the documents and information you provide to the IRO, the IRO will consider the following information (if they are available and the IRO considers them appropriate):

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by you, your treating provider, and the Benefits Administrator;
- The terms of the Plan and any information submitted about prior Plan benefits determinations in similar cases;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the Benefits Administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the IRO's clinical reviewer or reviewers after considering the information described above, to the extent the information or documents are available and the clinical reviewer or reviewers consider them to be appropriate.

The IRO will issue its final external review decision within 45 days after receiving your request for external review. Notice from the IRO will be sent to you and the Benefits Administrator and will include:

- A general description of the reason for the request for external review, including information sufficient to identify the claim – including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code (and its corresponding meaning), the treatment code (and its corresponding meaning), and the reason for the previous denial;
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either you or the Plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

You may contact the IRO for up to six years after the review to request copies of records related to that review, except where such disclosure would violate state or federal privacy laws.

If the IRO reverses the Benefit Administrator's prior determination, the Benefit Administrator – upon receipt of the notice of final external review – must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for your claim.

Expedited External Review

You have the right to make a request for an expedited external review of an adverse benefit determination if:

- You have filed a request for an expedited internal appeal (see [Urgent Care Claim Submission](#) on page 44), and the adverse benefit determination under review involves a medical condition for which the timeframe for completion of an expedited internal appeal procedure described above would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.
- You have received an adverse benefit determination after completion of the Plan's internal appeals process (see [Appeal of Denied Claims](#) on page 42), and you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from a facility.

Immediately upon receipt of your request for an expedited external review, the Benefits Administrator must determine whether:

- You were covered by the Plan at the time your claim was incurred;
- The adverse benefit determination is related to your eligibility to participate in the Plan;
- You have exhausted the internal appeals processes listed above; and
- You have provided all information and forms required to process an external review.

Upon determination that your request is eligible for external review following the preliminary review, the Benefits Administrator will assign an IRO to your claim the same way it would under a standard (non-expedited) external appeal. The Benefits Administrator must provide or transmit all necessary documents and information considered in making the adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard external review. In reaching its decision, the IRO will review the claim without regard to the Benefits Administrator's decision. In other words, the IRO will not be bound by any decisions or conclusions reached by the Benefits Administrator.

The IRO will provide a notice of a final external review decision in accordance with the procedures for a standard external review decision. However, the IRO will issue its decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you and the Benefits Administrator.

When Coverage Ends

Your coverage ends when you terminate employment for any reason, including layoff, or when you no longer meet Plan eligibility requirements. Your coverage also may end under the following circumstances:

- You elect not to participate during open enrollment or following a qualified change in status;
- You are no longer an eligible employee, including if your regular work schedule goes below 30 hours per week;
- All Plan coverage or certain benefits are terminated;
- You fail to make required contributions to the Plan; or
- You become represented by a collective bargaining unit that does not participate in the Plan.

Your dependents' coverage ends if:

- Your own coverage is terminated for any reason (unless you are enrolled as a retiree and you die in which case your surviving Spouse can continue coverage until he/she remarries);
- You fail to make the required contribution for dependent coverage;
- Dependent coverage under the Plan is amended or terminated; or
- Your dependent no longer qualifies as a dependent under the Plan.

Coverage generally ends on the last day of the month in which any event described above occurs. **Note:** For a layoff situation, your coverage will end at the end of the month following the month in which your layoff occurred. If you are covered under a collective bargaining agreement, your coverage ends in accordance with the terms of the CBA. However, if you are an Inpatient at the time your coverage ends, benefits will be provided in most cases for Covered Services until you are discharged.

If You Are On a Leave of Absence

If you are on a paid leave of absence, your coverage will continue and your contributions will continue to be deducted from your pay. If you are on an unpaid leave of absence, your payroll contributions will cease but you can continue your coverage by paying the required premiums through the end of your leave. Your Human Resources representative will let you know when your premium is due, amount owed, and what happens if you do not pay your premium. Contact your Human Resources representative for more details.

Family and Medical Leave Act of 1993 (FMLA)

Under the Family and Medical Leave Act of 1993 (FMLA), your Plan coverage may be continued during an approved leave covered by FMLA if you request the leave of absence:

- For your own health reasons;
- To care for an ill family member; or
- To care for a Child following birth or adoption.

If you do not want to continue coverage during your leave you may elect to opt out of coverage and upon return from your leave you may re-elect coverage. You will have 31 days to re-elect coverage upon your return from leave. Your coverage will begin on the first day of the month on or after your return from leave.

If you choose to continue your benefits during an approved FMLA leave, ITW will pay its share of the premium cost and you are required to pay your portion of the premium cost to keep the coverage in effect.

Military Leave of 31 Days or More

The Uniformed Services Employment and Reemployment Act of 1994, impacts your rights to health care coverage if you leave your job to enter military service (for 31 days or more). Under federal law, you may elect to continue your employee or dependent medical coverage for 24 months from the date civilian employment ended, or until the end of the period allowed for you to apply for reemployment, whichever is less. The actual length of time may vary depending on when you entered military duty and the length of time you have been in service. To keep your coverage in effect, you must pay the full cost of coverage plus a 2% administrative charge.

Continuation Coverage

If you do not return to active employment following a paid or unpaid leave of absence, or if certain other events occur, you and your dependents may be eligible for continuation coverage described in [COBRA Continuation Coverage](#) on page 50.

Retiree Medical Coverage

If you are eligible at retirement for continued medical benefits (as defined in the retirement plan documents), you will be directed to resources for additional information. The coverage provided under the Plan to retirees is the same as the coverage for active employees, except that the retiree pays the full cost for the Plan coverage. Also, Medicare is primary for retirees or enrolled dependents that are eligible for Medicare, as described in [Limitations on Plan Benefits](#) on page 34.

If Medicare is primary, you must be enrolled in Medicare Parts A and B in order to receive full benefits from the Plan. If you choose not to enroll in Part B coverage, you will pay more in out-of-pocket expenses. Here's why: After your claim is filed with Medicare and then submitted to the ITW Medical Plan, the Plan will consider what Medicare would have paid if you had both Part A and Part B coverage, even if you don't have Part B coverage. If you don't have Part B coverage, you will pay those Part B charges out of your own pocket.

If you are eligible at retirement for continued medical benefits, you will have the opportunity to elect retiree medical coverage in the Plan as follows:

- Within 31 days of a qualified change in status (such as your retirement, eligibility for Medicare or loss of other coverage);
- During open enrollment (held each Fall for a January 1 effective date); or
- Within 31 days of the exhaustion of:
 - ITW subsidized COBRA; or
 - Non-subsidized COBRA.

You must contact the ITW Benefits Service Center within the prescribed time to elect retiree medical coverage in the Plan.

Like other components of the Plan, the retiree coverage may be wholly or partially amended at any time, either prospectively or retroactively, by ITW. ITW also reserves the right to terminate or suspend retiree coverage at any time.

The list of Participating Business Units that have been designated for retiree medical benefits is maintained by the Employee Benefits Steering Committee and is available upon request. To determine your eligibility, contact your Human Resources representative.

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), you and your dependents may have the right under certain circumstances to elect continuation of coverage under the Plan. If you or your dependents suffer a loss of coverage due to a qualifying event (as described below), you will have 60 days to elect continuation of the same coverage that you had as an active employee.

Here are the events that could qualify you or your dependents for continuation coverage:

- **Termination of Employee/Reduction in Hours:** If your employment ends for any reason other than gross misconduct, or your hours are reduced below the amount required to be considered eligible for the Plan, you and your covered dependents may continue Plan coverage for up to 18 months.

An individual who elects COBRA continuation coverage due to the employee's termination of employment or reduction in hours, and who is determined by the Social Security Administration to be Disabled at the time of the employee's termination or reduction of hours or within the first 60 days of COBRA continuation coverage, may be eligible to extend the COBRA continuation coverage up to a total of 29 months. Covered dependents who are qualified beneficiaries also may extend coverage for that period. To qualify for this extension, the qualified beneficiary must provide the COBRA Benefit Administrator with written proof of the Disability from the Social Security Administration within 60 days of the date of the determination of Disability and prior to the end of the 18-month continuation period. The cost of Plan coverage for the additional 11 months will not exceed 150% of the full actual cost of the coverage. The qualified beneficiary must notify the COBRA Benefit Administrator within 31 days of a determination that the qualified beneficiary is no longer Disabled.

- **Divorce or Legal Separation:** In the event of divorce, legal separation, or dissolution of Domestic Partnership, your covered dependents may elect COBRA continuation coverage for up to a total of 36 months.
- **Loss of Dependent Child Status:** If a dependent Child loses eligibility (for instance, when he or she reaches the age limit), he or she may elect COBRA continuation coverage for up to a total of 36 months.
- **Death:** If you die, your dependents may elect COBRA continuation coverage for up to a total of 36 months.
- **Entitlement to Medicare:** If your entitlement to Medicare would cause your dependents to lose coverage, they may elect COBRA continuation coverage for up to a total of 36 months.

In all cases (except the Disability extension period as outlined above), you or your dependents are responsible for paying 102% of the full cost of coverage. You will have the same annual maximums as an active employee in the Plan. The amount of benefits you receive before a qualifying event extends your coverage will apply toward the maximums.

A Child born or adopted during a covered parent's period of COBRA continuation coverage also is eligible for COBRA continuation coverage as a qualified beneficiary.

Electing COBRA Continuation Coverage

The Plan will notify the ITW Benefits Service Center if your or your dependents' coverage ends because of termination, reduction in work hours, or your death. **For the other qualifying events (divorce, legal separation, or loss of dependent child status), you or your dependents are responsible for notifying the ITW Benefits Service Center within 60 days after the later of the date the qualifying event occurs or the date you would lose benefits under the Plan. In the event you fail to timely provide notice within 60 days, the Plan is not required to offer you and/or your dependent(s) the opportunity to elect COBRA.** The COBRA Benefit Administrator will, in turn, notify you and your covered dependents of your continuation rights and provide the appropriate election forms. If you misplace or do not receive your COBRA notice and election forms, contact the COBRA Benefits Administrator for assistance. You will not be required to provide proof of insurability to elect continuation coverage.

If you do not elect COBRA continuation coverage within 60 days of the date you lose coverage due to a qualifying event, your right to continue coverage under COBRA will terminate.

If you decide to continue coverage, you must return payment for the initial premium within 45 days of the date of your election. Subsequent payments are due on the premium due date and must be paid in full within the grace period (30 days). COBRA continuation coverage will stop before the end of the maximum continuation period if one of the following events occurs:

- You become eligible for Medicare;
- The Plan is terminated;
- You fail to pay the full cost for coverage on or before the due date; or
- You are covered under another group health plan, unless the plan contains exclusions that prevent you from receiving benefits under that plan.

Trade Adjustment Assistance

The Trade Act of 1974 provides for trade readjustment assistance for certain persons whose employment terminates because of increased imports or the shift of production to a foreign country. This trade adjustment assistance consists primarily of career counseling, up to two years of training, income support during training, job search assistance, and relocation allowances. A person who meets certain definitions in the Trade Act of 1974 may also be eligible for special rights under COBRA and for special income tax benefits related to the cost of health coverage.

A person who may be eligible for special rights under COBRA associated with trade adjustment assistance is referred to as a TAA-eligible individual. A TAA-eligible individual is a person who is either an eligible TAA recipient or an eligible alternate TAA recipient. These two terms are defined as follows:

- A person is an eligible TAA recipient as of the first day of a month if at any time during that month he or she receives trade adjustment assistance under Chapter 2 of Title II of the Trade Act of 1974 (or if he or she would be receiving such assistance but for the fact that he or she has not yet exhausted all of his or her unemployment benefits other than exclusively state-funded, non-federally-reimbursable unemployment benefits).

- A person is an eligible alternate TAA recipient for a month if he or she is at least 50 years of age, is part of a group of workers who the Secretary of Labor has certified as eligible for alternate trade adjustment assistance and is receiving such alternate trade adjustment assistance, and meets the following criteria:
 - He or she has obtained reemployment not more than 26 weeks after the date of separation from the adversely affected employment, and is employed on a full-time basis as defined by State law in the State in which he or she is employed; and
 - He or she earns not more than \$50,000 a year in wages from reemployment.

When an employee loses coverage under the Plan as the result of a termination of employment, and the termination of employment also leads to the employee's becoming certified by the appropriate government agency as a TAA-eligible individual, and the employee did not elect continuation coverage during the original 60-day election period following that termination of employment, the TAA-eligible individual is entitled to a second opportunity to elect continuation coverage for himself or herself and his or her dependents who are qualified beneficiaries. This second opportunity to elect continuation coverage is provided by giving the TAA-eligible individual a new election period that begins on the first day of the month during which he or she became a TAA-eligible individual and ends on the earlier of the date which is 60 days later or which is six months after the original loss of coverage as the result of the termination of employment. When a TAA-eligible individual elects continuation coverage in the second election period, the continuation coverage begins on the date the second election period began (not on the date when coverage under the Plan originally was lost).

Coverage Under Health Insurance Marketplace

There may be other coverage options for you and your family. You may elect to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Administrative Information

This section contains important information related to the administration of the ITW Medical Plan.

While ERISA does not require an employer to provide benefits, for those employers who choose to offer benefits it does set standards on how those benefits are administered. It also requires that you be kept fully informed of your rights and benefits, the details of which are included in this SPD.

Administrative Facts/Contact Information

Name of Plan		ITW Medical Plan
Type of Plan		Welfare Plan (group health plan)
Plan Identification Number		501
Plan Sponsor		Illinois Tool Works Inc. 155 Harlem Avenue Glenview, IL 60025 847.724.7500
Employer Identification Number	ITW's identification number (assigned by the IRS)	36-1258310
Plan Administrator	Illinois Tools Works Inc. For description of role and responsibilities, see Plan Administrator on page 54.	Illinois Tool Works Inc. Attn: Medical Plan Administrator 155 Harlem Avenue Glenview, IL 60025 847.724.7500
Plan Year	12-month period used to maintain financial records of the Plan	January 1 – December 31
ITW Benefits Service Center	For general information on the Plan	ITW Benefits Service Center P.O. Box 187 Bellaire, TX 77402-0187 866.416.4931
COBRA Benefit Administrator	Appointed by the Plan Administrator to make COBRA eligibility determinations and track COBRA premiums	ITW Benefits Service Center Attn: COBRA Benefits Administrator P.O. Box 187 Bellaire, TX 77402-0187 866.416.4931
Medical Benefits Administrator	Appointed or hired to make all initial determinations regarding claims for ITW Medical Plan benefits and to handle certain other administrative functions	Blue Cross Blue Shield of Illinois Full Service Unit 1125 Wall Street Jacksonville, IL 62650 800.325.0320 www.bcbsil.com/itw
Medical Claim Appeals		Blue Cross Blue Shield of Illinois Appeals Coordinator P.O. Box 2401 Chicago, IL 60690
Mental Health/ Substance Abuse Claim Appeals:		Blue Cross Blue Shield of Illinois P.O. Box 805107 Chicago, IL 60680
Pharmacy Benefits Administrator	Appointed or hired by the Plan Administrator to make all initial determinations regarding claims for Plan pharmacy benefits and to handle certain other administrative functions	CVS/caremark Customer Service P.O. Box 832407 Lee Summit, MO 64064-6590 888.437.4926 www.caremark.com
Prescription Drug Claim Appeals		CVS/caremark P.O Box 52084 Phoenix, AZ 85072-2084
Prescription Drug Reimbursement Requests		CVS/caremark P.O Box 52136 Phoenix, AZ 85072-2136

Continued...

Administrative Facts/Contact Information *(cont'd.)*

Service of Legal Process	Office of the General Counsel of ITW 155 Harlem Avenue Glenview, IL 60025 847.724.7500
Funding of the Plan	The PPO and CMM coverage options are both self-funded which means benefits are funded by contributions made by ITW and by covered individuals

Plan Administrator

The Plan Administrator is responsible for administering the Plan. The powers and duties of the Plan Administrator include:

- Within its complete and sole discretion, to construe and interpret the Plan and determine all questions arising in its operation, administration and application;
- To review any determination made by the Plan's benefit administrator, either on its own or through the claims review process;
- To adopt any rules, procedures and forms necessary for the operation and administration of the Plan that are consistent with its provisions;
- To determine all questions relating to the eligibility, benefits and other rights of covered individuals;
- To keep all records necessary to operate and administer the Plan;
- To retain any legal, accounting, medical or other expert advisers (who also may be advisers to ITW) in connection with the operation and administration of the Plan;
- To designate or employ agents (who also may be employees of ITW or any ITW business unit) and delegate to them the exercise of one or more specific powers of the Plan Administrator; and
- To comply with ERISA, including the preparation and distribution of notices to employees and reports to the IRS and Department of Labor.

No Contract of Employment

Nothing contained in this SPD will be construed as a contract of employment between ITW and any employee, or as a right of any employee to continue in the employment of ITW or as a limitation of its right to discharge any employee with or without cause.

Successor Company

In the event of the dissolution, merger, consolidation or reorganization of ITW, the Plan may or may not be continued by the successor. If the Plan is continued by the successor, the successor will be substituted for ITW under the Plan. The substitution of the successor will constitute an assumption of Plan liabilities by the successor and the successor will have all of the powers, duties and responsibilities of ITW under the Plan.

Applicable Law

The Plan will be construed and administered according to the laws of the State of Illinois to the extent such laws are not preempted by ERISA or subsequent amendments or any other laws of the United States of America.

Indemnification

The Employee Benefits Steering Committee shall be indemnified by ITW from and against any and all liability, joint or several, for their acts and omissions and for the acts and omissions of their agents and other fiduciaries in the administration and operation of the Plan. The Employee Benefits Steering Committee shall also be indemnified by ITW against all costs and expenses reasonably incurred by them in connection with the defense of any action, suit or proceeding related to the Plan, including the cost of reasonable settlements (other than amounts paid to ITW) made to avoid costs of litigation and payment of any judgment or decree entered in such action, suit or proceeding. ITW shall not, however, indemnify the Employee Benefits Steering Committee with respect to any act finally adjudicated to have been caused by willful misconduct or with respect to the cost of any settlement unless the settlement has been approved by a court of competent jurisdiction.

The right of indemnification shall not be exclusive of any other right to which the Employee Benefits Steering Committee may be legally entitled and it shall inure to the benefit of the duly appointed legal representatives of the Employee Benefits Steering Committee.

Amendment or Termination of the Plan

The Plan may be partially or wholly amended at any time, either prospectively or retroactively, by ITW. You will be informed of any changes that are made and told how the changes affect your benefits, if at all. ITW also reserves the right to terminate or suspend the Plan at any time. You and your covered dependents will be bound by the terms of any such amendment, modification, termination or suspension. No change in the Plan, or termination, will deprive you of any benefits to which you are entitled at the time of amendment or termination.

Your Rights to Benefits Under ERISA

As a participant in the ITW Medical Plan you are entitled to certain rights and protections under ERISA. ERISA provides that, as a program participant, you are entitled to the following rights.

Receive Information about Your Plans and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing any Plan that is a part of this program, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by a Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, Spouse (or Domestic Partner) or dependents if there is a loss of coverage under the ITW Medical Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing this Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit Plan. The people who operate this Plan (called fiduciaries) have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request a copy of the Plan's documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
- If you have a claim for benefits, which is denied or ignored in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Definitions of Key Terms

Applied Behavioral Analysis (ABA) Therapy: ABA Therapy is the science of controlling and predicting human behavior by focusing on the observable relationship of behavior to the environment. Research in ABA ranges from behavioral intervention methods to basic research which investigates the rules by which humans adapt and maintain behavior.

Brand-name Drug: A Brand-name Drug is an FDA-approved prescription drug manufactured under a trademark or a trade name. Under the Managed Prescription Drug Program, Brand-Name drugs are considered to be either Preferred Formulary Drugs or Non-Preferred Drugs.

Chemotherapy: Chemotherapy is the treatment of malignant tumors or tumorous conditions by pharmaceutical and/or biological anti-tumor drugs. Chemotherapy can be administered by a Physician or under his or her direct supervision. Chemotherapy services can be administered in an Inpatient, Outpatient, office, or home setting.

Child or Children: Children are natural children, stepchildren, children who are placed in your home for adoption, legally adopted children, foster children, and children for whom you (or your Spouse or Domestic Partner) are the sole permanent legal guardian. To be eligible for ITW Medical Plan coverage, a Child must be under age 26 or, if age 26 or older, incapacitated due to physical Disability or Mental Illness (see [Extended Coverage for Disability](#) on page 9).

Chiropractic Care: Chiropractic Care is the detection and correction, by manual or mechanical means, of the interference with nerve transmissions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column performed by a chiropractor.

Claim Charge: The amount that appears on a claim as the Provider's charge for a service provided to you, with no adjustment or reduction and regardless of any separate financial arrangement between the Medical Benefits Administrator and a particular Provider.

Coinsurance: Coinsurance is the percentage of an Eligible Charge that you are required to pay towards a Covered Service. For most services, once your share of these costs – the amount you pay in Deductible, Copayment and Coinsurance – reach the Plan's Out-of-Pocket Limit for the year, the Plan pays the full cost of Covered Services for the balance of the year.

Company: Illinois Tool Works Inc., a corporation organized and existing under the laws of the State of Delaware, or its successor or successors, and any corporation which together with Illinois Tool Works Inc. is a member of a controlled group of corporations under Code Sections 414(b) or (c).

Coordinated Home Health Care: Coordinated Home Health Care is an organized skilled patient care program in which care is provided in the home. Care may be provided by the Hospital's licensed home health department or by other licensed home health agencies. To qualify, you must be homebound (that is unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing service on an intermittent basis under the direction of your Physician. Coordinated Home Health Care does not include and is not intended to provide benefits for private duty nursing service and/or Custodial Care.

Copayment: A Copayment is a specified dollar amount that you are required to pay towards certain Covered Services. The amount of the Copayment depends on the type of service received. Copayments do not apply toward the annual Deductible but do apply to your Out-of-Pocket Limit.

Covered Service: A Covered Service is a service or supply for which benefits are provided under the Plan.

Custodial Care: Custodial Care is any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (for example, simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (for example, bathing, eating, dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement of your condition.

Deductible: The Deductible is the amount of expenses you pay each Plan Year before certain Plan benefits begin. There is no credit given for any Deductible amounts paid in the prior Plan Year.

Diagnostic Service (Testing): Diagnostic Service means tests which are performed for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

Disabled or Disability: Disabled (or under a Disability) means that, before termination of employment, you qualify for benefits under:

- ITW's long-term disability plan;
- An acquired business unit's long-term disability plan; or
- Workers' Compensation.

A Disability may not be self-inflicted, incurred in the commission of a crime, or suffered in the armed forces of the U.S. or U.N. and covered as such by a service disability allowance.

Domestic Partner: To qualify for coverage under the Plan, a Domestic Partner must be the same sex as the employee and the employee and Domestic Partner must:

- Register their Domestic Partnership or civil union with the state and/or municipality in which they reside – if available; or
- Marry – if the state in which they reside offers same-sex marriage – see Spouse.

If neither option is available, the employee and same-sex Domestic Partner must complete the Domestic Partner Affidavit Form. The affidavit requires that the employee and his or her prospective Domestic Partner certify that they:

- Are each other's sole same-sex partner and intend to be so indefinitely;
- Have been in an exclusive relationship for the past six months;
- Are not married to any other person;

- Are jointly responsible for one another's common well-being and financial obligations;
- Are not related by blood to the degree of closeness that would prohibit a legal marriage in the state in which they reside; and
- Have lived together in the same principal residence for at least six months and intend to do so indefinitely.

For a Domestic Partner Affidavit Form, contact the ITW Benefits Service Center.

Domestic Partnership: A Domestic Partnership is a same-sex relationship that satisfies the requirements listed under the definition of Domestic Partner above.

Eligible Charge: An Eligible Charge is the amount determined by the Medical Benefits Administrator that a health care facility with a written agreement with the Medical Benefits Administrator has agreed to accept as payment in full for a particular Covered Service. For a health care facility without a written agreement with the Medical Benefits Administrator, the Eligible Charge will be the lesser of:

- The Provider's billed charges; or
- The non-contracting Eligible Charge developed by the Medical Benefits Administrator from base Medicare reimbursements excluding any Medicare adjustments.

Emergency Accident Care: Emergency Accident Care is the initial Outpatient treatment of accidental injuries including necessary related Diagnostic Services that are obtained within 72 hours of the accident.

Emergency Medical Care: Emergency Medical Care is the initial treatment, including necessary related Diagnostic Services, of a medical condition (not caused by an accident) displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to:

- An apparent heart attack (severe chest pain, sweating, nausea);
- Uncontrollable bleeding;
- Loss of consciousness or confusion, especially after a head injury;
- Severe shortness of breath or difficulty breathing; and
- Severe or multiple injuries, including obvious fractures.

Conditions like colds, earaches, ordinary sprains, cuts that do not require stitches, and headaches are examples of conditions that usually aren't serious enough to be considered a medical emergency.

ERISA: ERISA means the federal Employee Retirement Income Security Act of 1974 and all its amendments.

Experimental or Investigational: Experimental or Investigational means procedures, services, drugs, devices and/or supplies which are:

- Provided or performed in special settings for research purposes or under controlled environments and which are being studied for safety, efficiency and effectiveness;
- Awaiting endorsement by the appropriate national medical specialty college or federal government agency for general use by the medical community at the time they are rendered to you; and/or
- Not finally approved by the Federal Drug Administration at the time used by or administered to you (specifically with regards to drugs, combinations of drugs and/or devices).

Treatments or procedures are considered Experimental and excluded under the Plan unless:

- The U.S. Food and Drug Administration has approved marketing the drug or device, if such approval is required by law (including approval for use in intended combinations with other drugs);
- Reliable evidence shows that the treatment, procedure, device or drug is not subject to ongoing Phase I, II or III clinical trials by or under study to determine its toxicity, safety, efficacy or maximum tolerated toxicity, or its efficacy as compared with the standard means of treatment or diagnoses; and
- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device or drug is that further studies or clinical trials are not necessary to determine its toxicity, safety, efficacy or maximum tolerated toxicity, or its efficacy as compared with the standard means of treatment or diagnoses. Reliable evidence includes anything determined as such by the Medical Benefits Administrator, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.

Generic Drug: An FDA-approved prescription drug that contains the same active ingredients as a Brand-Name Drug and is determined to be as effective for treating a particular condition as its Brand-Name equivalent or an FDA approved chemically equivalent copy designed from a Brand-Name Drug whose patent has expired. A Generic Drug is typically less expensive and sold under a common name for the drug, not the Brand-Name Drug.

Health Professional: A Physician, Psychologist, chiropractor, optometrist, podiatrist, clinical social worker or other eligible Provider who is either licensed as required by the state in which he or she practices, or, in the absence of such law, recognized by the applicable state association, and who is performing the services that he or she is trained to provide.

Home Health Care: See [Coordinated Home Health Care](#) on page 21.

Hospice: Hospice is a centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility or special hospice care unit.

Hospital: Hospital means a duly licensed institution for the care of the sick, which provides service under the care of Physicians, including regular bedside nursing by registered nurses. Health resorts, rest homes, nursing homes, Skilled Nursing Facilities, convalescent homes, custodial homes for the aged, or similar institutions are not Hospitals.

Inpatient: Inpatient means you are a registered bed patient and are treated as such in a health care facility.

ITW: ITW means Illinois Tool Works Inc., a corporation organized and existing under the laws of the State of Delaware, or its successor or successors, and any corporation which together with Illinois Tool Works Inc. is a member of a controlled group of corporations under Code Sections 414(b) or (c).

Maximum Allowance: Maximum Allowance means the amount determined by the Medical Benefits Administrator that Participating Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Providers will be based on the schedule of Maximum Allowances, which these Participating Providers have agreed to accept as payment in full. For Non-Participating Providers, the Maximum Allowance will be the lesser of:

- The Provider's billed charges; or
- The amount developed by the Medical Benefits Administrator from base Medicare reimbursements excluding any Medicare adjustments.

Medical Benefits Administrator: The Medical Benefits Administrator is the entity appointed or hired by the Plan Administrator to make all initial determinations regarding claims for Plan benefits and to handle certain other administrative functions. The Medical Benefits Administrator handles pre-authorization procedures, case management, claims processing and review of denied claims, and provides customer service for all of these functions. The Medical Benefits Administrator also sets the terms and conditions for benefit claims procedures (for example, determining whether a service is Medically Necessary).

Medically Necessary: Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of the Medical Benefits Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Medical Benefits Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

The Medical Benefits Administrator does not determine your course of treatment or whether you receive particular health care services. Decisions regarding the course of treatment and receipt of particular health care services are a matter entirely between you and your Physician. The Medical Benefits Administrator's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is a Covered Service under the Plan.

Remember that the Plan does not cover the cost of hospitalization or any health care services and supplies that are not determined to be Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as medically necessary,

the Medical Benefits Administrator will not pay for the hospitalization, services or supplies unless the Medical Benefits Administrator determines it to be Medically Necessary and a Covered Service under the Plan.

For purposes of the Prescription Drug Program, medications, health care services or products are considered Medically Necessary if, as determined by the Pharmacy Benefits Administrator, use of the medication, service, or product:

- Is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;
- Is based on recognized standards for the health care specialty involved;
- Represents the most appropriate level of care for you, based on the seriousness of the condition being treated, the frequency and duration of services, and the place where services are performed; and
- Is not solely for the convenience of you, your family, or provider.

A Medically Necessary determination does not guarantee that benefits are available. For example, it might be determined that a service is Medically Necessary, however, the Plan may limit or exclude that service. In that case, the Medically Necessary determination does not override the [What the ITW Medical Plan Does Not Cover](#) section (see page 29) or other sections of this SPD.

Medicare: Medicare is Parts A and B of the health care program for the aged and Disabled established by Title XVIII of the Social Security Act. This also includes Medicare Part C (Medicare Advantage Plans) and Medicare Part D (Medicare Prescription Drug Plan).

Medicare Allowance: Medicare Allowance means the maximum amount determined by the Center for Medicare and Medicaid Services (CMS) for reimbursement for specific services.

Mental Illness: Mental Illness means those illnesses classified as disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, which is current as of the date services are rendered to you.

Non-Preferred Drug: A Brand-Name prescription drug not included by the Pharmacy Benefits Administrator on its list of Preferred Formulary Drugs. You pay more when you and your Physician choose a Non-Preferred Drug compared with a Preferred Formulary or Generic Drug.

Occupational Therapy: Occupational Therapy means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

Out-of-Pocket Limit: This is the maximum amount you will pay toward the cost of Covered Services through the Copayments, Deductible and Coinsurance paid each year for each covered family member and for your family as a whole.

Outpatient: Outpatient means treatment outside of an Inpatient Hospital setting.

Participating Business Unit: Participating Business Unit means a division, plant, location, facility or department of ITW, which is designated by the Employee Benefits Steering Committee of ITW. Unless otherwise indicated by the Employee Benefits Steering Committee, all eligible employees of a Participating Business Unit shall be allowed to participate in the Plan. The Employee Benefits Steering Committee may determine that any division, plant, location, facility or department which was previously designated as eligible to participate in the Plan shall thereafter be ineligible to participate under such terms and conditions as it shall deem appropriate. The lists of Participating Business Units are maintained by the Plan Administrator and are available upon request.

Pharmacy Benefits Administrator: The Pharmacy Benefits Administrator is the entity appointed or hired by the Plan Administrator to make benefit determinations for the Managed Prescription Drug Program. The Pharmacy Benefits Administrator also handles claims processing and reviews denied claims, maintains the list of Preferred Formulary and Non-Preferred Drugs and provides customer service.

Physical Therapy: Physical Therapy means the treatment of a disease, injury or condition by physical means by a Physician or by a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

Physician: A physician shall mean a physician who is either licensed as required by the law of the state in which he or she practices, or, in the absence of such law, recognized by the applicable state association, and who is performing the services that he or she is trained to provide.

Plan: This term (with an initial capital P) is used throughout the SPD to refer to the ITW Medical Plan.

Plan Administrator: The Plan Administrator is ITW, or any person or committee appointed by the ITW Board of Directors to act in this capacity.

Plan Year: The Plan Year is the 12-month period used to maintain the financial records of the Plan and is the calendar year.

PPO Provider/Participating Provider: A PPO Provider or Participating Provider is an administrator Hospital, facility, or Professional Provider that has a written agreement with the Medical Benefits Administrator or another Blue Cross and/or Blue Shield Plan, to provide services to participants in a PPO program. An administrator facility, which has been designated by the Medical Benefits Administrator, may also be a Participating Provider. Generally, these Providers have agreed to reduce fees for participants of the Plan.

Preferred Formulary Drug: A Preferred Formulary Drug is a Brand-Name prescription drug included by the Pharmacy Benefits Administrator on its list of preferred drugs for treatment of particular conditions. The drugs have been clinically selected by an independent Pharmacy and Therapeutic Committee based on effectiveness and cost. The committee consists of a group of independent Physicians and pharmacists. You pay less when you and your doctor choose a Preferred Formulary Drug, compared with a Non-Preferred Drug.

Professional Provider: A Professional Provider is a Physician, dentist, podiatrist, Psychologist, chiropractor, optometrist, clinical social worker or any Provider designated by the Medical Benefits Administrator or another Blue Cross and/or Blue Shield Plan.

Provider: A Provider is any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician) or entity duly licensed to render Covered Services to you.

Psychologist: A Psychologist is a state-licensed psychologist who specializes in the evaluation and treatment of Mental Illness or, if practicing in a state where statutory licensure does not exist, such person must:

- Have a doctoral degree from a regionally accredited university, college, or professional school, and have two years of supervised experience as a psychologist in health services, of which at least one year is post-doctoral and one year is in an organized health services program; or
- Have a graduate degree in psychology from a regionally accredited university or college and have not less than six years experience as a psychologist, with at least two years of supervised experience in health services.

Skilled Nursing Facility: A Skilled Nursing Facility is an institution, or a distinct part of an institution, which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services. Institutions that provide only minimal care, Custodial Care, ambulatory or part-time care services or institutions that primarily provide for mental health or Substance Abuse treatment are not Skilled Nursing Facilities.

Specialty Medications: Specialty Medications are often high-cost biological, injectable, infused, oral or inhaled drugs that have special delivery and storage requirements (for example, drugs that need refrigeration). Most Specialty Medications are used to treat chronic diseases but in some cases, they are used to treat very rare disorders.

Speech Therapy: Speech Therapy is treatment for correction of a speech impairment resulting from disease, including pervasive developmental disorders, trauma, congenital anomalies or previous therapeutic processes which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training, treatment of psychosocial speech delay, treatment for behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation or services designed and adapted to develop a physical function.

Spouse: A Spouse is a husband or a wife of the employee resulting from a legal marriage. Spouse includes your opposite sex common-law spouse only if your common-law status is recognized in your state of legal residency.

Substance Abuse: Substance Abuse is the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring medical care as determined by a Physician or Psychologist. This definition shall be applied consistently with applicable state and federal law and consistently with generally recognized independent standards of medical practice.

Substance Abuse Treatment Facility: A Substance Abuse Treatment Facility is a facility, other than a Hospital, whose primary function is the treatment of Substance Abuse and is licensed by the appropriate state and local authority to provide these services. It does not include halfway houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided.

EXHIBIT H

Your Health Care Benefit Program



Participating Provider Option



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.®

A message from

BLUE CROSS AND BLUE SHIELD

This booklet is your Certificate of Health Care Benefits. It describes the health care benefit program that we have arranged for you. This program is underwritten by Health Care Service Corporation, a Mutual Legal Reserve Company, the Blue Cross and Blue Shield Plan serving the state of Illinois.

We are pleased to offer this program to you and your family. We believe it will help relieve you of many financial worries should you have health care expenses.

Sincerely,

A message from

BLUE CROSS AND BLUE SHIELD

Health Care Service Corporation, a Mutual Legal Reserve Company, the Blue Cross and Blue Shield Plan serving the state of Illinois will provide the health care benefits described in this benefit program. Like most people, you probably have many questions about your coverage. This Certificate contains a great deal of information about the services and supplies for which benefits will be provided under your benefit program. Please read your entire Certificate very carefully. We hope that most of the questions you have about your coverage will be answered.

In this Certificate we refer to our company as “Blue Cross and Blue Shield” and we refer to the company that you work for as the “Group.” The Definitions Section will explain the meaning of many of the terms used in this Certificate. All terms used in this Certificate, when defined in the Definitions Section, begin with a capital letter. Whenever the term “you” or “your” is used, we also mean all eligible family members who are covered under Family Coverage.

If you have any questions once you have read this Certificate, talk to your Group Administrator or call us at your local Blue Cross and Blue Shield office. It is important to all of us that you understand the protection this coverage gives you.

Welcome to Blue Cross and Blue Shield! We are very happy to have you as a member and pledge you our best service.

Sincerely,

Blue Cross and Blue Shield of Illinois,
A Division of Health Care Service Corporation,
A Mutual Legal Reserve Company

A handwritten signature in black ink, reading "Karen Atwood". The signature is fluid and cursive, with the first name "Karen" and last name "Atwood" clearly distinguishable.

Karen Atwood
President

of 1230
NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for Blue Cross and Blue Shield to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those Providers.

Please refer to the provision entitled “Blue Cross and Blue Shield’s Separate Financial Arrangements with Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

The use of a metallic name, such as Platinum, Gold, Silver or Bronze, or other statements with respect to a health benefit plan’s actuarial value, is not an indicator of the actual amount of expenses that a particular person will be responsible to pay out of his/her own pocket. A person’s out of pocket expenses will vary depending on many factors, such as the particular health care services, health care providers and particular benefit plan chosen. Please note that metallic names reflect only an approximation of the actuarial value of a particular benefit plan.

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

**WARNING, LIMITED BENEFITS WILL BE PAID WHEN
NON-PARTICIPATING PROVIDERS ARE USED**

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy’s fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

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BENEFIT HIGHLIGHTS

Plan Name: Blue PPO Gold 016

Network Name: PPO (Participating Provider Option) Network

Your benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire Certificate.

**THE MEDICAL SERVICES
ADVISORY PROGRAM**

A special program designed to assist you in determining the course of treatment that will maximize your benefits under this Certificate

MSA®'

Registered Mark of
Health Care Service Corporation
a Mutual Legal Reserve Company

**Lifetime Maximum
for all Benefits**

Unlimited

Individual Deductible

- Participating Provider \$1,800 per benefit period
- Non-Participating and
Non-Plan Provider \$3,600 per benefit period

Family Deductible

- Participating Provider \$4,000 per benefit period
- Non-Participating and
Non-Plan Provider \$8,000 per benefit period

**Individual Out-of-Pocket
Expense Limit
(does not apply to all services)**

- Participating Provider \$4,000 per benefit period
- Non-Participating and
Non-Plan Provider \$8,000 per benefit period
- Non-Plan Provider No limit

**Family Out-of-Pocket
Expense Limit
(does not apply to all services)**

- Participating Provider \$12,000 per benefit period
- Non-Participating and
Non-Plan Provider \$24,000 per benefit period
- Non-Plan Provider No limit

HOSPITAL BENEFITS

Payment level for Covered
Services from a

Participating Provider:

- Inpatient Deductible \$200 per admission
- Inpatient Covered Services 90% of the Eligible Charge
- Outpatient Surgical Deductible \$150 per admission
- Outpatient Covered Services 90% of the Eligible Charge

Payment level for Covered
Services from a

Non-Participating Provider:

- Inpatient Deductible \$300 per admission
- Inpatient Covered Services 70% of the Eligible Charge
- Outpatient Surgical Deductible \$250 per admission
- Outpatient Covered Services 70% of the Eligible Charge

Payment level for Covered
Services from a

Non-Plan Provider

50% of the Eligible Charge

Hospital Emergency Care

- Payment level for Emergency Accident Care from either a Participating, Non-Participating or Non-Plan Provider 90% of the Eligible Charge, no deductible
- Payment level for Emergency Medical Care from either a Participating, Non-Participating or Non-Plan Provider 90% of the Eligible Charge, no deductible

Emergency Room

\$400 Copayment
(waived if admitted to the Hospital
as an Inpatient immediately following
emergency treatment)

PHYSICIAN BENEFITS

Payment level for Surgical/
Medical Covered Services

- **Participating Provider** 90% of the Maximum Allowance
- **Non-Participating Provider** 70% of the Maximum Allowance

Payment level for
Covered Services received in a
Professional Provider's Office

- Participating Provider
(other than a specialist) \$20 per visit, then 100% of the
Maximum Allowance, no deductible
- Participating Provider
Specialist \$40 per visit, then 100% of the
Maximum Allowance, no deductible

Payment level for Emergency
Accident Care 90% of the Maximum Allowance,
no deductible

Payment level for Emergency
Medical Care 90% of the Maximum Allowance,
no deductible

Preventive Care Services

- **Participating Provider** 100% of the Maximum Allowance or
Eligible Charge
- **Non-Participating Provider** 70% of the Maximum Allowance or
Eligible Charge

OTHER COVERED SERVICES

Payment level 90% of the Eligible Charge
or Maximum Allowance

**TO IDENTIFY NON-PLAN AND PLAN HOSPITALS OR FACILITIES,
YOU SHOULD CONTACT BLUE CROSS AND BLUE SHIELD BY
CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE
NUMBER ON YOUR BLUE CROSS AND BLUE SHIELD IDENTIFICA-
TION CARD.**

PRESCRIPTION DRUG PROGRAM BENEFITS

Copayment for drugs and supplies

- Formulary Generic Drugs and
Formulary generic
diabetic supplies and insulin
and insulin syringes \$0 per prescription
- Non-Formulary Generic Drugs
and Non-Formulary generic
diabetic supplies and insulin
and insulin syringes \$10 per prescription

- Formulary Brand Name Drugs and Formulary brand name diabetic supplies and insulin and insulin syringes \$35 per prescription
- Non-Formulary Brand Name Drugs and non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is no Generic Drug or supply available \$75 per prescription
- Non-Formulary Brand Name Drugs and non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is a Generic Drug or supply available \$75 per prescription, plus the cost difference between the Generic and Brand Name Drugs or supplies per prescription
- Specialty Drugs \$150 per prescription

Home Delivery Prescription Drug Program

Copayment for drugs and supplies

- Formulary Generic Drugs and Formulary generic diabetic supplies and insulin and insulin syringes \$0 per prescription
- Non-Formulary Generic Drugs and Non-Formulary generic diabetic supplies and insulin and insulin syringes \$20 per prescription
- Formulary Brand Name Drugs and Formulary brand name diabetic supplies and insulin and insulin syringes \$70 per prescription
- Non-Formulary Brand Name Drugs and non-Formulary brand name diabetic supplies and insulin and insulin syringes for which there is no Generic Drug or supply available \$150 per prescription

- Non-Formulary Brand Name
Drugs and non-Formulary
brand name diabetic supplies
and insulin and insulin syringes
for which there is a Generic
Drug or supply available \$150 per prescription, plus the cost
difference between the Generic
and Brand Name Drugs or supplies
per prescription

PEDIATRIC VISION COVERAGE PROGRAM BENEFITS		
Vision Care Services	In-Network Member Cost or Discount	Out-of-Network Allowance
	(When a fixed-dollar co-payment is due from the member, the remainder is payable by the plan up to the covered charge*)	(maximum amount payable by plan, not to exceed the retail cost)**
Exam (with dilation as necessary):	No Copayment	Up to \$30
Frames:		
<p>“Collection” frame***</p> <p>Note: Frames covered by this Certificate are limited to the Pediatric Frame Collection of covered frames. The network provider will show you the collection of frames covered by this Certificate. If you select a frame that is not included in the Pediatric Frame Collection, covered under this Certificate, you are responsible for the difference in cost between the network provider reimbursement amount for covered frames from the Pediatric Frame Collection and the retail price of the frame selected. Any amount paid to the network provider for the difference in cost of a non-Pediatric Frame Collection frame will not apply to any applicable deductible, coinsurance or out-of-pocket limit.</p>	No Copayment	Up to \$30
Frequency:		
Examination, Lenses, or Contact Lenses	Once every 12-month benefit period	
Frame	Once every 12-month benefit period	

Standard Plastic, Glass, or Poly-Spectacle Lenses: Single Vision Lined Bifocal Lined Trifocal Lenticular Lenses include choice of glass or plastic lenses, all lenses powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses. Note: Polycarbonate lenses are covered in full for children, monocular patients and patients with prescriptions \geq +/- 6.00 diopeters. Note: All lenses include scratch resistant coating with no additional copayment. There may be an additional charge at Walmart and Sam's Club.	No Copayment No Copayment No Copayment No Copayment	Up to \$25 Up to \$35 Up to \$45 Up to \$45
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<p>Lens Options (add to lens prices above):</p> <p>Ultraviolet Protective Coating</p> <p>Polycarbonate Lenses</p> <p>Blended Segment Lenses</p> <p>Intermediate vision Lenses</p> <p>Standard Progressives</p> <p>Premium Progressive (Varilux®, etc.)</p> <p>Photochromic Glass Lenses</p> <p>Plastic Photosensitive Lenses (Transitions®)</p> <p>Polarized Lenses</p> <p>Standard Anti-Reflective (AR) Coating</p> <p>Premium AR Coating</p> <p>Ultra AR Coating</p> <p>High Index Lenses</p> <p>Progressive Lens Options – Members may receive a discount on additional progressive lens options:</p> <p> Select Progressive Lenses</p> <p> Ultra Progressive Lenses</p> <p>Scratch Protection</p> <p>Single Vision</p> <p>Multifocal Lens</p>	<p>No Copayment</p> <p>No Copayment</p> <p>\$20 Copayment</p> <p>\$30 Copayment</p> <p>No Copayment</p> <p>\$90 Copayment</p> <p>\$20 Copayment</p> <p>No Copayment</p> <p>\$75 Copayment</p> <p>\$35 Copayment</p> <p>\$48 Copayment</p> <p>\$60 Copayment</p> <p>\$55 Copayment</p> <p>\$70 Copayment</p> <p>\$195 Copayment</p> <p>\$20 Copayment</p> <p>\$40 Copayment</p>	<p>Not covered</p> <p>Not covered</p>
<p>Contact Lenses: covered once every calendar year – in lieu of eyeglasses</p> <p>Elective</p>	<p>Maximum of 2 boxes per calendar year</p>	<p>Up to \$75</p>

of 1230

<p>Medically Necessary contact lenses – preauthorization is required</p> <p>Note: Contact lenses covered by this Certificate are limited to the Pediatric Contact Lens Collection. The network provider will inform you of the contact lens collection covered by this Certificate. If you select a contact lens that is not part of the Pediatric Contact Lens Collection covered under this Certificate, you are responsible for the difference in cost between the network provider reimbursement amount for covered contact lenses available from the Pediatric Contact Lens Collection and the retail price of the contact lenses selected. Any amount 1) paid to the network provider for the difference in cost of a non-Pediatric Contact Lens Collection contact lens or 2) that exceeds the Maximum Covered Fees for non-network provider supplied contacts will not apply to any applicable deductible, coinsurance or out-of-pocket limit.</p>	<p>100% of the Eligible Charge or Maximum Allowance</p>	<p>Up to \$225</p>
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Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.

Value-added features:

Laser vision correction: You will receive a discount for traditional LASIK and custom LASIK from participating Physicians and affiliated laser centers. You must obtain Preauthorization for this service. *Prices/discounts may vary by state and are subject to change without notice.*

Mail-order contact lens replacement: Lens 1-2-3® Program (visit the Lens 1-2-3 website: www.lens123.com).

Additional Benefits

Medically Necessary contact lenses: Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions:

keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.

Medically necessary contact lenses are dispensed in lieu of other eyewear. Participating providers will obtain the necessary preauthorization for these services.

Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our members with low vision.

With prior approval from BCBSIL, members who require low-vision services and optical devices are entitled to the following coverage, both in- and out-of-network:

Low Vision Evaluation: One comprehensive evaluation every five years (out-of-network maximum allowance of \$300). This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast and lighting requirements for optimum vision.

Low-Vision Aid: Covered for one device per year such as high-power spectacles, magnifiers and telescopes (out-of-network maximum allowance of \$600 per device and \$1200 lifetime). These devices are utilized to maximize use of available vision, reduce problems of glare or increase contrast perception, based on the individual's visual goals and lifestyle needs.

Follow-up care: Four visits in any five-year period (out-of-network maximum allowance of \$100 per visit).

Warranty: Warranty limitations may apply to provider or retailer supplied frames and/or eyeglass lenses. Please ask your provider for details of the warranty that is available to you.

* The “covered charge” is the rate negotiated with Network Providers for a particular covered service.

** The Plan pays the lesser of the maximum allowance noted or the retail cost. Retail prices vary by location.

*** In and Out-of-Network Benefit Offering and Non-Collection Frames: Frames covered by this policy are limited to the Pediatric Frame Collection of covered frames. The network provider will show you the selection of frames covered by this policy. If you select a frame that is not included in the Pediatric Frame Collection covered under this policy, you are responsible for the difference in cost between the network provider reimbursement amount for covered frames from the Pediatric Frame Collection and the retail price of the frame selected. If frames are provided by a non-network provider, benefits are limited to the amount shown above in the “Schedule of Benefits.” Any amount 1) paid to the network provider for the difference in cost of a non-Pediatric Frame Collection frame or 2) that exceeds the Maximum Covered Fee for a non-network provider supplied frame will not apply to any applicable deductible, coinsurance, or out-of-pocket maximum/out-of-pocket limit/out-of-pocket coinsurance maximum.

DEFINITIONS SECTION

Throughout this Certificate, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this Certificate, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

ADVANCED PRACTICE NURSE.....means a Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist.

AMBULANCE TRANSPORTATION.....means local transportation in a specially equipped certified vehicle from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.

AMBULATORY SURGICAL FACILITY.....means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

A "Plan Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Plan Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which does not meet the definition of a Plan Ambulatory Surgical Facility.

ANESTHESIA SERVICES.....means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them respectively.

APPROVED CLINICAL TRIAL.....means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and is one of the following:

- (i) A federally funded or approved trial,
- (ii) A clinical trial conducted under an FDA investigational new drug application, or

- (iii) A drug that is exempt from the requirement of an FDA investigational new drug application.

AUTISM SPECTRUM DISORDER(S).....means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder and pervasive developmental disorders not otherwise specified.

AVERAGE DISCOUNT PERCENTAGE ("ADP").....means a percentage discount determined by Blue Cross and Blue Shield that will be applied to a Provider's Eligible Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by Blue Cross and Blue Shield to be relevant to the particular Claim. The ADP reflects Blue Cross and Blue Shield's reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect related costs. (See provisions of this Certificate regarding "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers.") In determining the ADP applicable to a particular Claim, Blue Cross and Blue Shield will take into account differences among Hospitals and other facilities, Blue Cross and Blue Shield's contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when your benefits under this Certificate are secondary to Medicare and/or coverage under any other group program.

AVERAGE WHOLESALE PRICE.....means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

BEHAVIORAL HEALTH PRACTITIONER.....means a Physician or Professional Provider who is duly licensed to render services for Mental Illness, Serious Mental Illness or Substance Use Disorder.

CERTIFICATE.....means this booklet, including your application(s) for coverage under the Blue Cross and Blue Shield benefit program described in this booklet.

CERTIFICATE OF CREDITABLE COVERAGE.....means a certificate disclosing information relating to your Creditable Coverage under a health care benefit program.

CERTIFIED CLINICAL NURSE SPECIALIST.....means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical con-

sultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- (ii) is a graduate of an advanced practice nursing program.

A “Participating Certified Clinical Nurse Specialist” means a Certified Clinical Nurse Specialist who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Clinical Nurse Specialist” means a Certified Clinical Nurse Specialist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE-MIDWIFE.....means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- (ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

A “Participating Certified Nurse-Midwife” means a Certified Nurse-Midwife who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Nurse-Midwife” means a Certified Nurse-Midwife who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE PRACTITIONER.....means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- (ii) is a graduate of an advanced practice nursing program.

A “Participating Certified Nurse Practitioner” means a Certified Nurse Practitioner who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Nurse Practitioner” means a Certified Nurse Practitioner who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED REGISTERED NURSE ANESTHETIST or CRNA.....means a nurse anesthetist who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

A “Participating Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CHEMOTHERAPY.....means the treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

CHIROPRACTOR.....means a duly licensed chiropractor.

CIVIL UNION.....means a legal relationship between two persons, of either the same or opposite sex, established pursuant to or as otherwise recognized by the Illinois Religious Freedom Protection and Civil Union Act.

CLAIM.....means notification in a form acceptable to Blue Cross and Blue Shield that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which Blue Cross and Blue Shield may request in connection with services rendered to you.

CLAIM CHARGE.....means the amount which appears on a Claim as the Provider’s charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between Blue Cross and Blue Shield and a particular Provider. (See provisions of this Certificate regarding “Blue Cross and Blue Shield’s Separate Financial Arrangements with Providers.”)

CLAIM PAYMENT.....means the benefit payment calculated by Blue Cross and Blue Shield, after submission of a Claim, in accordance with the benefits de-

scribed in this Certificate. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between Blue Cross and Blue Shield and a particular Provider. (See provisions of this Certificate regarding “Blue Cross and Blue Shield’s Separate Financial Arrangements with Providers.”)

CLINICAL LABORATORY.....means a clinical laboratory which complies with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, the Medicare and Medicaid programs and any applicable state and local statutes and regulations.

A “Participating Clinical Laboratory” means a Clinical Laboratory which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Laboratory” means a Clinical Laboratory which does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL PROFESSIONAL COUNSELOR.....means a duly licensed clinical professional counselor.

A “Participating Clinical Professional Counselor” means a Clinical Professional Counselor who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Professional Counselor” means a Clinical Professional Counselor who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL SOCIAL WORKER.....means a duly licensed clinical social worker.

A “Participating Clinical Social Worker” means a Clinical Social Worker who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Social Worker” means a Clinical Social Worker who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this Certificate.

COINSURANCE.....means a percentage of an eligible expense that you are required to pay towards a Covered Service.

COMPLICATIONS OF PREGNANCY.....means all physical effects suffered as a result of pregnancy which would not be considered the effect of normal pregnancy.

CONGENITAL OR GENETIC DISORDER.....means a disorder that includes, but is not limited to, hereditary disorders, Congenital or Genetic Disorders may also include, but are not limited to, Autism or an Autism Spectrum Disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma or injury.

COORDINATED HOME CARE PROGRAM.....means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

A "Plan Coordinated Home Care Program" means a Coordinated Home Care Program which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time service is rendered to you.

A "Non-Plan Coordinated Home Care Program" means a Coordinated Home Care Program which does not have an agreement with a Blue Cross and/or Blue Shield Plan but has been certified as a home health agency in accordance with the guidelines established by Medicare.

COPAYMENT.....means a specified dollar amount that you are required to pay towards a Covered Service.

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE.....means the date on which your coverage under this Certificate begins.

COVERED SERVICE.....means a service or supply specified in this Certificate for which benefits will be provided.

CREDITABLE COVERAGE.....means coverage you had under any of the following:

- (i) A group health plan.
- (ii) Health insurance coverage for medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.
- (iii) Medicare (Parts A or B of Title XVIII of the Social Security Act).
- (iv) Medicaid (Title XIX of the Social Security Act).
- (v) Medical care for members and certain former members of the uniformed services and their dependents.
- (vi) A medical care program of the Indian Health Service or of a tribal organization.
- (vii) A State health benefits risk pool.
- (viii) A health plan offered under the Federal Employees Health Benefits Program.
- (ix) A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country.
- (x) A health benefit plan under section 5(e) of the Peace Corps Act.
- (xi) State Children's Health Insurance Program (Title XXI of the Social Security Act).

CUSTODIAL CARE SERVICE.....means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you.

DENTIST.....means a duly licensed dentist.

DIAGNOSTIC SERVICE.....means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-ray, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.

DIALYSIS FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

A “Plan Dialysis Facility” means a Dialysis Facility which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Plan Dialysis Facility” means a Dialysis Facility which does not have an agreement with a Blue Cross and/or Blue Shield Plan but has been certified in accordance with the guidelines established by Medicare.

DOMESTIC PARTNER.....means a person with whom you have entered into a Domestic Partnership.

DOMESTIC PARTNERSHIP.....means long-term committed relationship of indefinite duration with a person which meets the following criteria:

- (i) you and your Domestic Partner have lived together for at least 6 months,
- (ii) neither you nor your Domestic Partner is married to anyone else or has another domestic partner,
- (iii) your Domestic Partner is at least 18 years of age and mentally competent to consent to contract,
- (iv) your Domestic Partner resides with you and intends to do so indefinitely,
- (v) you and your Domestic Partner have an exclusive mutual commitment similar to marriage, and
- (vi) you and your Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider.

A “Participating Durable Medical Equipment Provider” means a Durable Medical Equipment Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Durable Medical Equipment Provider” means a Durable Medical Equipment Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

EARLY ACQUIRED DISORDER.....means a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talk-

ing or self-help skills. Early Acquired Disorder may include, but is not limited to, Autism or an Autism Spectrum Disorder and cerebral palsy.

ELIGIBLE CHARGE.....means (a) in the case of a Provider, other than a Professional Provider, which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider, other than a Professional Provider, which does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, will be the lesser of:

- (i) the Provider's billed charges, or;
- (ii) Blue Cross and Blue Shield of Illinois non-contracting Eligible Charge. Except as otherwise provided in this section, the non-contracting Eligible Charge is developed from base Medicare reimbursements and represents approximately 105% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Eligible Charge for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating or Non-Plan Provider's standard billed charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Eligible Charge for Non-Participating or Non-Plan Providers will be 50% of the Non-Participating or Non-Plan Provider's standard billed charge for such Covered Service.

Blue Cross and Blue Shield of Illinois will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Provider Claims for processing Claims submitted by Non-Participating or Non-Plan Providers which may also alter the Eligible Charge for a particular service. In the event Blue Cross and Blue Shield of Illinois does not have any Claim edits or rules, Blue Cross and Blue Shield of Illinois may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by Blue Cross and Blue Shield of Illinois within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

ELIGIBLE PERSON.....means an employee of the Group who meets the eligibility requirements for this health coverage, as described in the **ELIGIBILITY SECTION** of this Certificate.

EMERGENCY ACCIDENT CARE.....means the initial Outpatient treatment of accidental injuries including related Diagnostic Service.

EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (ii) serious impairment to bodily functions; or
- (iii) serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

EMERGENCY MENTAL ILLNESS or SUBSTANCE USE DISORDER ADMISSION.....means an admission for the treatment of Mental Illness or Substance Use Disorder as a result of the sudden and unexpected onset of a Mental Illness or Substance Use Disorder such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

EMERGENCY SERVICES.....means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and, within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize the patient.

ENROLLMENT DATE.....means the first day of coverage under your Group's health plan or, if your Group has a waiting period prior to the effective date of your coverage, the first day of the waiting period (typically, the date employment begins). No such waiting period may exceed 90 days unless permitted by applicable law. If our records show that your Group has a waiting period that exceeds the time period permitted by applicable law, then we reserve the right to begin your coverage on a date that we believe is within the required period. Regardless of whether we exercise that right, your Group is responsible for your

waiting period. If you have questions about your waiting period, please contact your Group.

FAMILY COVERAGE.....means coverage for you and your eligible spouse and/or dependents under this Certificate.

GROUP POLICY or POLICY.....means the agreement between Blue Cross and Blue Shield and the Group, any addenda, this Certificate, the Group's application and the Plan, as appropriate, along with any exhibits, appendices, addenda and/or other required information and the individual application(s) of the persons covered under the Policy.

HABILITATIVE SERVICES.....means Occupational Therapy, Physical Therapy, Speech Therapy, and other services prescribed by a Physician pursuant to a treatment plan to enhance the ability of a child to function with a Congenital, Genetic, or Early Acquired Disorder.

HOME INFUSION THERAPY PROVIDER.....means a duly licensed home infusion therapy provider.

A "Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

HOSPICE CARE PROGRAM PROVIDER.....means an organization duly licensed to provide Hospice Care Program Service.

HOSPICE CARE PROGRAM SERVICE.....means a centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility or special hospice care unit.

HOSPITAL.....means a duly licensed institution under state law for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses, irrespective of whether the institution provides surgery on its premises or at another licensed hospital pursuant to a formal written agreement between the two institutions. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

A "Plan Hospital" means a Hospital which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Plan Hospital" means a Hospital that does not meet the definition of a Plan Hospital.

A "Participating Hospital" means a Plan Hospital that has an agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide Hospital services to participants in a Participating Provider Option program.

A "Non-Participating Hospital" means a Plan Hospital that does not meet the definition of a Participating Hospital.

INDIVIDUAL COVERAGE.....means coverage under this Certificate for yourself but not your spouse and/or dependents.

INPATIENT.....means that you are a registered bed patient and are treated as such in a health care facility.

INTENSIVE OUTPATIENT PROGRAM.....means a freestanding or Hospital-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat Mental Illness or Substance Use Disorder or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorder. Dual diagnosis programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions which make it unlikely that you will benefit from programs that focus solely on Mental Illness conditions. Dual diagnosis programs are delivered by Behavioral Health Practitioners who are cross-trained.

Intensive Outpatient Program services may be available with less intensity if you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder. If you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder, services may include psychotherapy, pharmacotherapy, and other interventions aimed at supporting recovery such as the development of recovery plans and advance directives, strategies for identifying and managing early warning signs of relapse, development of self-management skills, and the provision of peer support services.

Intensive Outpatient Programs may be used as an initial point of entry into care, as a step up from routine Outpatient services, or as a step down from acute Inpatient, residential care or a Partial Hospitalization Treatment Program.

INVESTIGATIONAL or INVESTIGATIONAL SERVICES AND SUPPLIES.....means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically

with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

LONG TERM CARE SERVICES.....means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury or condition.

MAINTENANCE CARE.....means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY.....means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

MARRIAGE AND FAMILY THERAPIST (“LMFT”).....means a duly licensed marriage and family therapist.

A “Participating Marriage and Family Therapist” means a Marriage and Family Therapist who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Marriage and Family Therapist” means a Marriage and Family Therapist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

MATERNITY SERVICE.....means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

MAXIMUM ALLOWANCE.....means (a) the amount which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Professional Providers will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. (b) For Non-Participating Professional Providers, the Maximum Allowance will be the lesser of:

- (i) the Provider’s billed charges, or;
- (ii) Blue Cross and Blue Shield of Illinois non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 105% of the base

Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Maximum Allowance for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating Professional Provider's standard billed charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Maximum Allowance for Non-Participating Professional Providers will be 50% of the Non-Participating Professional Provider's standard billed charge for such Covered Service.

Blue Cross and Blue Shield of Illinois will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Professional Provider Claims for processing Claims submitted by Non-Participating Professional Providers which may also alter the Maximum Allowance for a particular service.

In the event Blue Cross and Blue Shield of Illinois does not have any Claim edits or rules, Blue Cross and Blue Shield of Illinois may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by Blue Cross and Blue Shield of Illinois within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

MEDICAL CARE.....means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

MEDICALLY NECESSARY.....Medically Necessary means that a specific medical, health care, supply or Hospital service is required, for the treatment or management of a medical symptom or condition and that the service, supply or care provided is the most efficient and economical service which can safely be provided.

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that Blue Cross and Blue Shield will pay the cost of the hospitalization, services or supplies.

Blue Cross and Blue Shield will make the initial decision whether hospitalization or other health care services or supplies were not Medically Necessary. In most instances this initial decision is made by Blue Cross and Blue Shield AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED. In making decisions of whether the hospitalization or other health care service(s) or supply(ies) are not Medically Necessary, and therefore not eligible for payment under the terms of your Certificate, Blue Cross and Blue Shield will take into account the information submitted to Blue Cross and Blue Shield by the member's Provider(s), including any consultations with such Providers(s).

Hospitalization or other health care is not Medically Necessary when, applying the definition of Medical Necessity to the circumstances surrounding the hospitalization or other health care, it is determined that, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with Blue Cross and Blue Shield's initial decision, your policy provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against Blue Cross and Blue Shield, either at law or in equity. To initiate your appeal, you must give Blue Cross and Blue Shield written notice of your intention to do so as described in the HOW TO FILE A CLAIM section of this Certificate.

Below are some examples, not an exhaustive list, of hospitalization or other health care services and supplies that are not Medically Necessary:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
- Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.

- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

MEDICARE.....means the program established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.).

MEDICARE APPROVED or MEDICARE PARTICIPATING.....means a Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

MEDICARE SECONDARY PAYER or MSP.....means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

MENTAL HEALTH UNIT.....means a unit established to assist in the administration of Mental Illness and Substance Use Disorder Rehabilitation Treatment benefits including Preauthorization, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Use Disorder.

MENTAL ILLNESS.....means those illnesses classified as disorders in the current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

“Serious Mental Illness”.....means the following mental disorders as classified in the current *Diagnostic and Statistical Manual* published by the American Psychiatric Association:

- (i) Schizophrenia;
- (ii) Paranoid and other psychotic disorders;
- (iii) Bipolar disorders (hypomanic, manic, depressive and mixed);
- (iv) Major depressive disorders (single episode or recurrent);
- (v) Schizoaffective disorders (bipolar or depressive);
- (vi) Pervasive developmental disorders;
- (vii) Obsessive-compulsive disorders;
- (viii) Depression in childhood and adolescence;
- (ix) Panic disorder;
- (x) Post-traumatic stress disorders (acute, chronic, or with delayed onset); and
- (xi) Anorexia nervosa and bulimia nervosa.

NAPRAPATH.....means a duly licensed naprapath.

NAPRAPATHIC SERVICES.....means the performance of naprapathic practice by a Naprapath which may legally be rendered by them.

NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PLAN HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-PLAN PROVIDER.....SEE DEFINITION OF PROVIDER.

OCCUPATIONAL THERAPIST.....means a duly licensed occupational therapist.

OCCUPATIONAL THERAPY.....means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

OPTOMETRIST.....means a duly licensed optometrist.

A “Participating Optometrist” means an Optometrist who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Optometrist” means an Optometrist who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ORTHOTIC PROVIDER.....means a duly licensed orthotic provider.

A “Participating Orthotic Provider” means an Orthotic Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Orthotic Provider” means an Orthotic Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an

emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PARTIAL HOSPITALIZATION TREATMENT PROGRAM.....means a Blue Cross and Blue Shield approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Rehabilitation Treatment in which patients spend days or nights.

PARTICIPATING PRESCRIPTION DRUG PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER OPTION.....means a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

PHARMACY.....means any licensed establishment in which the profession of pharmacy is practiced.

PHYSICAL THERAPIST.....means a duly licensed physical therapist.

PHYSICAL THERAPY.....means the treatment of a disease, injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider.

PLAN HOSPITAL.....SEE DEFINITION OF HOSPITAL.

PLAN PROVIDER.....SEE DEFINITION OF PROVIDER.

PODIATRIST.....means a duly licensed podiatrist.

PREAUTHORIZATION, PREAUTHORIZE or EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION RE-

VIEW.....means a submission of a request to the Mental Health Unit for a determination of Medically Necessary care under this Certificate.

PRIVATE DUTY NURSING SERVICE.....means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PROSTHETIC PROVIDER.....means a duly licensed prosthetic provider.

A “Participating Prosthetic Provider” means a Prosthetic Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Prosthetic Provider” means a Prosthetic Provider who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you.

A “Plan Provider” means a Provider which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Plan Provider” means a Provider that does not meet the definition of Plan Provider unless otherwise specified in the definition of a particular Provider.

A “Participating Provider” means a Plan Hospital or Professional Provider which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to participants in a Participating Provider Option program or a Plan facility or Professional Provider which has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider.

A “Non-Participating Provider” means a Plan Hospital or Professional Provider which does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to participants in a Participating Provider Option program or a facility which has not been designated by Blue Cross and Blue Shield of Illinois as a Participating Provider.

A “Professional Provider” means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist, Clinical Social Worker or any Provider

designated by Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan.

A “Participating Professional Provider” means a Professional Provider who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and/or Blue Shield Plan to provide services to participants in a Participating Provider Option program or a Professional Provider who has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Professional Provider.

A “Participating Prescription Drug Provider” means a Pharmacy that has a written agreement with a Blue Cross and/or Blue Shield Plan, or with the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, to provide services to you at the time you receive the services.

PSYCHOLOGIST.....means a Registered Clinical Psychologist.

Registered Clinical Psychologist means a Clinical Psychologist who is registered with the Illinois Department of Financial and Professional Regulation pursuant to the Illinois “Psychologists Registration Act” or, in a state where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program; or

is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

RESCISSION.....means a cancellation or discontinuance of coverage that has retroactive effect except to the extent attributable to a failure to timely pay premiums.

REGISTERED SURGICAL ASSISTANT.....means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant.

A “Participating Registered Surgical Assistant” means a Registered Surgical Assistant who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A “Non-Participating Registered Surgical Assistant” means a Registered Surgical Assistant who does not have a written agreement with Blue Cross

and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

RENAL DIALYSIS TREATMENT.....means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

RESIDENTIAL TREATMENT CENTER.....means a facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with Mental Illness and/or Substance Use Disorder.

RESPIRE CARE SERVICE.....means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services for you.

RETAIL HEALTH CLINIC.....means a health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services by Certified Nurse Practitioners.

A "Participating Retail Health Clinic" means a Retail Health Clinic who has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A "Non-Participating Retail Health Clinic" means a Retail Health Clinic who does not have a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

SERIOUS MENTAL ILLNESS.....SEE DEFINITION OF MENTAL ILLNESS.

SKILLED NURSING FACILITY.....means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

A "Plan Skilled Nursing Facility" means a Skilled Nursing Facility which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered to you.

A "Non-Plan Skilled Nursing Facility" means a Skilled Nursing Facility which does not have an agreement with Blue Cross and Blue Shield of

Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan but has been certified in accordance with guidelines established by Medicare.

An “Uncertified Skilled Nursing Facility” means a Skilled Nursing Facility which does not meet the definition of a Plan Skilled Nursing Facility and has not been certified in accordance with the guidelines established by Medicare.

SKILLED NURSING SERVICE.....means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

SMALL EMPLOYER (Employer).....means a person (individual, corporation, partnership, or other legal entity) who employed an average of at least two employees but not more than 50 Eligible Persons on business days during the preceding Calendar Year and who employs at least two employees on the first day of the plan year.

SPEECH THERAPIST.....means a duly licensed speech therapist.

SPEECH THERAPY.....means the treatment for the correction of a speech impairment resulting from disease including pervasive developmental disorders, trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

SUBSTANCE USE DISORDER.....means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility. It does not include programs consisting primarily of counseling by individuals (other than a Behavioral Health Practitioner), court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

SUBSTANCE USE DISORDER TREATMENT FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment of Substance Use Disorder and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or

other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

A “Plan Substance Use Disorder Treatment Facility” means a Substance Use Disorder Treatment Facility which has a written agreement with Blue Cross and Blue Shield of Illinois or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered to you.

A “Non-Plan Substance Use Disorder Treatment Facility” means a Substance Use Disorder Treatment Facility that does not meet the definition of a Plan Substance Use Disorder Treatment Facility.

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by Blue Cross and Blue Shield.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

TOBACCO USER.....means a person who is permitted under state and federal law to legally use Tobacco, with Tobacco use (other than religious or ceremonial use of Tobacco), occurring on average four or more times per week that last occurred within the past six months (or such other meaning required or permitted by applicable law). Tobacco includes, but is not limited to, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, etc. For additional information, please call the number on the back of your identification card or visit our Web site at www.bcbsil.com.

TOTALLY DISABLED.....means with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

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ELIGIBILITY

Subject to the other terms and conditions of the Group Policy, the benefits described in this Certificate will be provided to persons who:

- Meet the definition of an Eligible Person as specified in the Group Policy;
- Have applied for this coverage;
- Have received a Blue Cross and Blue Shield identification card;
- Live within the service area of Blue Cross and Blue Shield. (Contact your Group or Customer Services at 1-800-892-2803 for information regarding service area.); and,
- Reside, live or work in the geographic network service area served by Blue Cross and Blue Shield for this Certificate of coverage. You may call customer service at the number shown on the back of your identification card to determine if you are in the network service area or log on to the Web site at www.bcbsil.com.

Replacement of Discontinued Group Coverage

When your Group initially purchases this coverage and such coverage is purchased as replacement of coverage under another carrier's group policy, those persons who are Totally Disabled on the effective date of this Policy and were covered under the prior group policy will be considered Eligible Persons under this Certificate.

Your Totally Disabled dependents will be considered eligible dependents under this Certificate if such dependents meet the description of an eligible family member as specified in the Eligibility Section of this Certificate.

Your dependent children who have reached the limiting age of this Certificate will be considered eligible dependents under this Certificate if they were covered under the prior group policy and, because of a handicapped condition, are incapable of self-sustaining employment and dependent upon you or other care providers for lifetime care and supervision.

If you are Totally Disabled, you will be entitled to all of the benefits described in this Certificate. The benefits of this Certificate will be coordinated with the benefits under your prior group policy. Your prior group policy will be considered the primary coverage for all services rendered in connection with your disabling condition when no coverage is available under this Certificate due to the absence of coverage in this Certificate.

APPLYING FOR COVERAGE

You may apply for coverage for yourself and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents (see below) by submitting the application(s) for medical insurance form, along with any exhibits, appendices, addenda and/or other required information ("Application(s)") to Blue Cross and Blue Shield.

You can get the application form from your Group Administrator. An application to add a newborn to Family Coverage is not necessary if an additional

premium is not required. However, you must notify your Group Administrator within 31 days of the birth of a newborn child for coverage to continue beyond the 31 day period or you will have to wait until your Group's open enrollment period to enroll the child.

The Application(s) for coverage may or may not be accepted. Please note, some employers only offer coverage to their employees, not to their employees' spouses, party to a Civil Union, Domestic Partner or dependents. In those circumstances, the references in this Certificate to an employee's family members are not applicable.

No eligibility rules or variations in premium will be imposed based on your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status factor. You will not be discriminated against for coverage under this Certificate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Variations in the administration, processes or benefits of this Certificate that are based on clinically indicated, reasonable management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination. Variations in the administration, processes or benefits of this policy that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

A Tobacco User may be subject to a premium of up to 1.5 times the rate applicable to those who are not Tobacco Users, to the extent permitted by applicable law, provided that Blue Cross and Blue Shield will provide an opportunity to offset such premium variation through participation in a wellness program to prevent or reduce Tobacco Use, if required by applicable law.

You may enroll in or change coverage for yourself and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents during one of the following enrollment periods. Your and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents' effective date will be determined by the Blue Cross and Blue Shield, depending upon the date your application is received and other determining factors.

Blue Cross and Blue Shield may require acceptable proof (such as copies of legal adoption or legal guardianship papers, or court orders) that an individual qualifies as an Eligible Person and/or family member under this Certificate.

Annual Open Enrollment Periods/Effective Date of Coverage

Your Group will designate annual open enrollment periods during which you may apply for or change coverage for yourself and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents.

This section "Annual Open Enrollment Periods/Effective Date of Coverage" is subject to change by Blue Cross and Blue Shield and/or applicable law, as appropriate.

SPECIAL ENROLLMENT PERIODS**Special Enrollment Periods/Effective Dates of Coverage**

Special Enrollment Periods have been designated during which you may apply for or change coverage for yourself and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents. You must apply for or request a change in coverage within 30 days from the date of a special enrollment event, except as otherwise provided below, in order to qualify for the changes described in this Special Enrollment Periods/Effective Dates of Coverage section.

Except as otherwise provided below, if you apply between the 1st day and the 15th day of the month, your effective date will be the 1st day of the following month, or if you apply between the 16th day and the end of the month, your and your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents' effective date will be the 1st day of the second following month.

Special Enrollment Events:

1. You gain or lose a dependent or become a dependent through marriage, becoming a party to a Civil Union or establishment of a Domestic Partnership, provided your employer covers Domestic Partners. New coverage for you and/or your eligible spouse, party to a Civil Union or Domestic Partner, provided your employer covers Domestic Partners, and/or dependents will be effective on the first day of the following month.
2. You gain or lose a dependent through birth, adoption, or placement of a foster child or for adoption or court-ordered dependent coverage. New coverage for you and/or your eligible spouse, party to a Civil Union or Domestic Partner, provided your employer covers Domestic Partners, and/or dependents will be effective on the date of the birth, adoption, or placement of a foster child or for adoption. However, the effective date for court-ordered eligible child coverage will be determined by the provisions of the court order.
3. You lose eligibility for coverage under a Medicaid plan or a state child health plan under title XXI of the Social Security Act. You must request coverage within 60 days of loss of coverage.
4. You become eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or state child health plan. You must request coverage within 60 days of such eligibility.

This section "Special Enrollment Periods/Effective Date of Coverage" is subject to change by Blue Cross and Blue Shield and/or applicable law, as appropriate.

Other Special Enrollment Events/Effective Dates of Coverage

You must apply for or request a change in coverage within 30 days from the date of the below other special enrollment events in order to qualify for the changes described in this Other Special Enrollment Events/Effective Dates of Coverage section.

Except as otherwise provided below, if you apply between the 1st day and the 15th day of the month, your effective date will be the 1st day of the following month, or if you apply between the 16th day and the end of the month, you and your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents' effective date will be the 1st day of the second following month.

1. Loss of eligibility as a result of:
 - Legal separation, divorce, or dissolution of a Civil Union or a Domestic Partnership, provided your employer covers Domestic Partners;
 - Cessation of dependent status (such as attaining the limiting age to be eligible as a dependent child under this Certificate);
 - Death of an Employee;
 - Termination of employment, reduction in the number of hours of employment.
2. Loss of coverage through an HMO in the individual market because you and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents no longer reside, live, or work in the network service area.
3. Loss of coverage through an HMO, or other arrangement, in the group market because you and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents no longer reside, live, or work in the network service area, and no other coverage is available to you and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents.
4. You incur a claim that would meet or exceed a lifetime limit on all benefits.
5. Loss of coverage due to a Policy no longer offering benefits to the class of similarly situated individuals that include you.
6. Your employer ceases to contribute towards your or/your dependent's coverage (excluding COBRA continuation coverage).
7. COBRA continuation coverage is exhausted.

Coverage resulting from any of the special enrollment events outlined above is contingent upon timely completion of the Application(s) and remittance of the appropriate premiums in accordance with the guidelines as established by Blue Cross and Blue Shield. Your spouse, party to a Civil Union, Domestic Partner and other dependents are not eligible for a special enrollment period if the Group does not cover dependents.

This section "SPECIAL ENROLLMENT PERIODS" is subject to change by Blue Cross and Blue Shield and/or applicable law, as appropriate.

NOTIFICATION OF ELIGIBILITY CHANGES

It is the Eligible Person's responsibility to notify Blue Cross and Blue Shield of any change to an Eligible Person's name or address or other changes to eligibility. Such changes may result in coverage/benefit changes for you and your eligible family members. For example, if you move out of Blue Cross and Blue Shield's "network service area". You must reside, or live or work in the geographic "network service area" designated by Blue Cross and Blue Shield. You may call Customer Service at the number shown on your ID card to determine if

you live in the network service area, or log on to the Web site at www.bcbstil.com.

INDIVIDUAL COVERAGE

If you have Individual Coverage, only your own health care expenses are covered, not the health care expenses of other members of your family.

FAMILY COVERAGE

Under Family Coverage, your health care expenses and those of your enrolled spouse, party to a Civil Union, Domestic Partner and your (and/or your spouse, party to a Civil Union, Domestic Partner's) enrolled children who are under the limiting age specified below will be covered.

All of the provisions of this Certificate that pertain to a spouse also apply to a party of a Civil Union unless specifically noted otherwise. A Domestic Partner and his/her children who have not attained the limiting age specified below may also be eligible dependents, provided your employer covers Domestic Partners. All of the provisions of this Certificate that pertain to a spouse may also apply to a Domestic Partner unless specifically noted otherwise, provided your employer covers Domestic Partners.

"Child(ren)" used hereafter in this Certificate, means a natural child(ren), a stepchild(ren), foster child(ren), adopted child(ren), a child(ren) of your party to a Civil Union or Domestic Partner (provided your employer covers Domestic Partners), a child(ren) who is in your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, a child(ren) of your child(ren), grandchild(ren), child(ren) for whom you are the legal guardian under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of those factors. In addition, enrolled unmarried children will be covered up to the age of 30 if they:

- Live within the service area of Blue Cross and Blue Shield's network for this Certificate; and
- Have served as an active or reserve member of any branch of the Armed Forces of the United States; and
- Have received a release or discharge other than a dishonorable discharge.

Coverage will continue under the Certificate for an eligible dependent who is unable to maintain full-time student status as a result of a medically necessary leave of absence or any other change in enrollment, provided that:

- The dependent is enrolled under the Certificate on the basis of being a student at a postsecondary educational institution; and
- The dependent was covered immediately before the first day of the medically necessary leave of absence or other change in enrollment; and
- The dependent child's treating Physician provides to Blue Cross and Blue Shield a written certification stating that the child is suffering from a seri-

ous illness or injury and that the leave of absence or other change in enrollment is medically necessary.

Coverage for such a dependent may be continued under the Certificate until the date that is the earlier of:

- One year after the first day of the medically necessary leave of absence or other change in enrollment; or
- The date on which such coverage would otherwise terminate under the terms of the Certificate.

The first day of the medically necessary leave of absence will be documented as the date indicated by the physician in the written certification on which the medical leave or other enrollment change is to begin.

Coverage for children will end on the last day of the period for which premium has been accepted.

If you have Family Coverage, newborn children will be covered from the moment of birth. Please notify Blue Cross and Blue Shield within 31 days of the birth so that your membership records can be adjusted. Your Group Administrator can tell you how to submit the proper notice through Blue Cross and Blue Shield.

Children who are under your legal guardianship or who are in your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, and foster children will be covered. In addition, if you have children for whom you are required by court order to provide health care coverage, those children will be covered.

Any children who are incapable of self-sustaining employment and are dependent upon you or other care providers for lifetime care and supervision because of a handicapped condition occurring prior to reaching the limiting age will be covered regardless of age as long as they were covered prior to reaching the limiting age.

This coverage does not include benefits for grandchildren (unless such children have been legally adopted or are under your legal guardianship).

Coverage under this Certificate is contingent upon timely receipt by Blue Cross and Blue Shield of necessary information and initial premium.

MEDICARE ELIGIBLE COVERED PERSONS

A series of federal laws collectively referred to as the “Medicare Secondary Payer” (MSP) laws regulate the manner in which certain employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, dependent children. Reference to spouse under this section do not include a party to a Civil union with the Eligible Person, the Domestic Partner (provided your employer covers Domestic Partners) of the Eligible Person or their children.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer group health plan (“GHP”) coverage, as well as certain other factors, including the size of the employers sponsoring the GHP.

In general, Medicare pays secondary to the following:

1. GHPs that cover individuals with end-stage renal disease (“ESRD”) during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has “current employment status.”
2. In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual’s spouse (of any age) has “current employment status.” If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).
3. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual’s family has “current employee status.”

If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

Please see your employer or Group Administrator if you have any questions regarding the ESRD Primary Period or any other provisions of the MSP laws and their application to you, your spouse or your dependents.

Your MSP Responsibilities

In order to assist your employer in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from Blue Cross and Blue Shield and/or your employer regarding the Medicare eligibility of you, your spouse and covered dependent children. In addition, if you, your spouse or covered dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact your employer or your group administrator promptly to ensure that your claims are processed in accordance with applicable MSP laws.

YOUR IDENTIFICATION CARD

You will receive an identification (ID) card from Blue Cross and Blue Shield. Your ID card contains your identification number. Do not let anyone who is not named in your coverage use your card to receive benefits. If you want additional cards or need to replace a lost card, contact Customer Service or go to www.bcbsil.com and get a temporary card online. Always carry your ID card with you.

LATE APPLICANTS

If you do not apply for Family Coverage or to add dependents within the allotted time, you will have to wait until your Group's annual open enrollment period to do so.

TERMINATION OF COVERAGE

If Blue Cross and Blue Shield terminates your coverage in this Certificate for any reason, Blue Cross and Blue Shield will provide you with a notice of termination of coverage that includes the termination effective date and reason for termination at least 30 days prior to the last day of coverage, except as otherwise provided in this Certificate.

Your and your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents' coverage will be terminated due to the following events and will end on the dates specified below:

1. The termination date specified by you, if you provide reasonable notice.
2. When the Blue Cross and Blue Shield does not receive the full amount of the premium payment or other charge or amount on time or when there is a bank draft failure of premiums for your and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents' coverage and the grace period, if any, has been exhausted.
3. You no longer live, reside or work in Blue Cross and Blue Shield's service area or and live, work, reside in Network Service Area.
4. Your coverage has been rescinded.

Upon termination of your coverage under this Certificate, you may request a Certificate of Creditable Coverage within 24 months of termination of your or your dependent's coverage under this Certificate.

Termination of a Dependent's Coverage

If one of your dependents no longer meets the description of an eligible family member as provided above under the heading "Family Coverage," his/her coverage will end as of the date the event occurs which makes him/her ineligible (for example, date of divorce). Coverage for children will end on the last day of the calendar month in which they reach the limiting age as shown in this Certificate.

WHO IS NOT ELIGIBLE

The following individuals are not eligible for this coverage:

1. Non-citizens or non-nationals of the United States, who are non-citizens and not lawfully present in the United States, and are not reasonably expected to be a citizen, national, or a non-citizen who is not lawfully present for the entire period for which open enrollment is sought. Please see the Initial and Annual Open Enrollment Periods/Effective date of Coverage of this Certificate.
2. Incarcerated individuals, other than incarcerated individuals pending disposition of charges,

3. Individuals that do not live, reside or work in the network service area.
4. Individuals that do not meet Blue Cross and Blue Shield's eligibility requirements or residency standards, as appropriate.

This section "WHO IS NOT ELIGIBLE" is subject to change by Blue Cross and Blue Shield and/or applicable law, as appropriate.

Extension of Benefits in Case of Discontinuance of Coverage

If you are Totally Disabled at the time your entire Group terminates, benefits will be provided for (and limited to) the Covered Services described in this Certificate which are related to the disability. Benefits will be provided when no coverage is available under the succeeding carrier's policy due to the absence of coverage in the policy. Benefits will be provided for a period of no more than 12 months from the date of termination. It is your responsibility to notify Blue Cross and Blue Shield, and to provide, when requested by Blue Cross and Blue Shield, written documentation of your disability. This extension of benefits does not apply to the Outpatient Prescription Drug Program.

CONVERSION PRIVILEGE

If your coverage under this Certificate should terminate and you want to continue Blue Cross and Blue Shield coverage with no interruption, you may do so if you have been insured under this coverage for at least 3 months and your Group has not cancelled this coverage and replaced it with other coverage. Here is what to do:

1. Tell Blue Cross and Blue Shield or your Group Administrator that you wish to continue your coverage and you will be provided with the necessary application.
2. Send the application and first premium to Blue Cross and Blue Shield within 31 days of the date you leave your Group or within 15 days after you have been given written notice of the conversion privilege, but in no event later than 60 days after you leave your Group.

Having done so, you will then be covered by Blue Cross and Blue Shield on an individual "direct pay" basis. This coverage will be effective from the date your Group coverage terminates so long as the premiums charged for the direct pay coverage are paid when due.

These direct pay benefits (and the premium charged for them) may not be exactly the same as the benefits under this Certificate. However, by converting your coverage, your health care benefits are not interrupted and you will not have to repeat waiting periods (if any).

Should any or all of your dependents become ineligible for coverage under this Certificate, they may convert to direct pay coverage by following the instructions stated above.

Upon the death of an Eligible Person, dependents under his or her family coverage will have the option to continue coverage for a period of 90 days subject to any other Certificate provisions relating to termination of such person's coverage, provided such person makes payment for coverage.

Eligibility for Child-Only Coverage

Eligible children that have not attained age 21 may enroll as the sole enrollee under this health care plan. In such event, this health care plan is considered child-only coverage and the following restrictions apply:

- Each child is enrolled individually as the sole enrollee; the parent or legal guardian is not covered and is not eligible for benefits under this health care plan.
- No additional dependents may be added to the enrolled child's coverage. Each child must be enrolled in his/her own plan. **Note: If a child covered under this plan acquires a new eligible child of his/her own, the new eligible child may be enrolled in his/her own plan coverage if application for coverage is made within 30 days.**
- If a child is under the age of 18, his/her parent, legal guardian, or other responsible party must submit the application for child-only insurance form, along with any exhibits, appendices, addenda and/or other required information to the Plan, as appropriate. For any child under 18 covered under this health care plan, any obligations set forth in this Plan, any exhibits, appendices, addenda and/or other required information will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the child's behalf. Application for child-only coverage will not be accepted for an adult child that has attained age 21 as of the beginning of the plan year. Adult children (at least 18 years of age but have not attained age 21) who are applying as the sole enrollee under this plan must apply for their own individual plan and must sign or authorize the application(s).

MEDICAL SERVICES ADVISORY PROGRAM

Blue Cross and Blue Shield has established the Medical Services Advisory Program (MSA) to perform a review of the following Covered Services **prior to** such services being rendered:

- Inpatient Hospital services
- Skilled Nursing Facility services
- services received in a Coordinated Home Care Program
- Private Duty Nursing Services

The MSA Program is staffed primarily by registered nurses and other personnel with clinical backgrounds. The Physicians in our Medical Department are an essential part of the MSA Program.

Failure to contact the MSA or to comply with the determinations of the MSA will result in a reduction in benefits. The MSA's toll-free telephone number is on your Blue Cross and Blue Shield identification card. Please read the provisions below very carefully.

NOTE: When you choose to receive Covered Services, from a Participating Provider in Illinois, you will not be responsible for notifying the MSA, and the provisions of this MSA PROGRAM section will not apply to you.

The provisions of the MSA PROGRAM section do not apply to the treatment of Mental Illness and Substance Use Disorder Rehabilitation Treatment. The provisions for the treatment of Mental Illness and Substance Use Disorder Rehabilitation Treatment are specified in the BLUE CROSS AND BLUE SHIELD MENTAL HEALTH UNIT section of this Certificate.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate, if any.

Whenever a nonemergency or nonmaternity Inpatient Hospital admission is recommended by your Physician, you must, in order to receive maximum benefits under this Certificate, call the MSA. This call must be made at least one business day prior to the admission.

The Hospital and your Physician will be advised by telephone, with a follow-up notification letter sent to you, your Physician and the Hospital if the proposed admission or any of the health care services are not Medically Necessary. The MSA will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission.

- **Emergency Admission Review**

Emergency admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate, if any.

In the event of an emergency admission, you or someone who calls on your behalf must, in order to receive maximum benefits under this Certificate, notify the MSA no later than two business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

- **Maternity Admission Review**

Maternity admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Certificate.

In the event of a maternity admission, you or someone who calls on your behalf must, in order to receive maximum benefits under this Certificate, notify the MSA no later than two business days after the admission has occurred in order to have the Inpatient Hospital admission reviewed. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

Even though you are not required to call the MSA prior to your maternity admission, if you call the MSA as soon as you find out you are pregnant, the MSA will begin to monitor your case. When you contact the MSA, you will be asked to answer a series of questions regarding your pregnancy. The MSA will provide you with educational materials which will be informative for you and which you may want to discuss with your Physician. A letter will be sent to your Physician stating that you contacted the MSA. The MSA will monitor your case and will be available should you have questions about your maternity benefits.

- **Skilled Nursing Facility Preadmission Review**

Skilled Nursing Facility preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate, if any.

Whenever an admission to a Skilled Nursing Facility is recommended by your Physician, you must, in order to receive maximum benefits under this Certificate, call the MSA. This call must be made at least one business day prior to the scheduling of the admission. When you call the MSA, a case manager may be assigned to you for the duration of your care.

- **Coordinated Home Care Program Preadmission Review**

Coordinated Home Care Program preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility

and the other terms, conditions, limitations, and exclusions of this Certificate, if any.

Whenever an admission to a Coordinated Home Care Program is recommended by your Physician, you must, in order to receive maximum benefits under this Certificate, call the MSA. This call must be made at least one business day prior to the scheduling of the admission. When you call the MSA, a case manager may be assigned to you for the duration of your care.

- **Private Duty Nursing Service Review**

Private Duty Nursing Service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate, if any.

Whenever Private Duty Nursing Service is recommended by your Physician, you must, in order to receive maximum benefits under this Certificate, call the MSA. This call must be made at least one business day prior to receiving services. When you call the MSA, a case manager may be assigned to you for the duration of your care.

CASE MANAGEMENT

After your case has been evaluated, you may be assigned a case manager. In some cases, if your condition would require care in a Hospital or other health care facility, the case manager may recommend an alternative treatment plan. If you and your Physician choose the alternative treatment plan, then alternative benefits will be provided as described in this Certificate.

The case manager will continue to monitor your case for the duration of your condition. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under this Certificate.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of this Certificate.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate, if any.

Upon completion of the preadmission or emergency review, the MSA will send you a letter confirming that you or your representative called the MSA. A letter assigning a length of service or length of stay will be sent to your Physician and/or the Hospital.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. In the event that the extension is determined not to be Medically Necessary, the length

of stay/service will not be extended, and the case will be referred to a Blue Cross and Blue Shield Physician for review.

MEDICALLY NECESSARY DETERMINATION

Inpatient care or other health care services or supplies must be Medically Necessary. Should the Blue Cross and Blue Shield Physician concur that the Inpatient care or other health care services or supplies are not Medically Necessary, written notification of the decision will be provided to you, your Physician, and/or the Hospital or other Provider, and will specify the dates or services that are not in benefit. For further details regarding Medically Necessary care and other exclusions from coverage under this Certificate, see the section entitled, "EXCLUSIONS—WHAT IS NOT COVERED."

The MSA does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Physician. The MSA's initial determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is Medically Necessary under this Certificate.

Remember that your Blue Cross and Blue Shield Certificate does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, Blue Cross and Blue Shield will not pay for the hospitalization, services or supplies if the MSA and the Blue Cross and Blue Shield Physician decide they were not Medically Necessary.

MSA PROCEDURE

When you contact the MSA, you should be prepared to provide the following information:

1. the name of the attending and/or admitting Physician;
2. the name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the MSA, the MSA:

1. will review the medical information provided and may follow up with the Provider;
2. may advise as to what Blue Cross and Blue Shield would consider as Medically Necessary.

APPEAL PROCEDURE

If you or your Physician disagree with the determination of the MSA prior to or while receiving services, you may appeal that decision by contacting the MSA or the Blue Cross and Blue Shield Medical Director.

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter from the MSA, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Medical Director
Health Care Service Corporation
P. O. Box A3957
Chicago, Illinois 60601

You must exercise the right to this appeal as a precondition to taking any action against Blue Cross and Blue Shield, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to Blue Cross and Blue Shield as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may review any relevant documents held by Blue Cross and Blue Shield, if you request an appointment in writing.

Within 30 days of receiving your request for review, Blue Cross and Blue Shield will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period. Depending on your situation, you may also request a claim review as described in the, "Claim Appeal Procedures" section in the HOW TO FILE A CLAIM section of this Certificate.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the MSA will not interfere with your relationship with any Provider. However, Blue Cross and Blue Shield has established the MSA program for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits provided under this Certificate.

Should you fail to notify the MSA as required in the Preadmission Review provision of this section, you will then be responsible for the first \$1,000 of the Hospital or facility charges for an eligible stay or \$1,000 of the charges for eligible Covered Services for Private Duty Nursing in addition to any deductibles, Copayments and/or Coinsurance applicable to this Certificate. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this Certificate nor can it be applied to your out-of-pocket expense limit, if applicable to this Certificate.

MEDICARE ELIGIBLE MEMBERS

The provisions of this Medical Services Advisory Program do not apply to you if you are Medicare Eligible and have secondary coverage provided under this Certificate.

BLUE CROSS AND BLUE SHIELD MENTAL HEALTH UNIT

The Blue Cross and Blue Shield Mental Health Unit has been established to assist in the administration of Mental Illness and Substance Use Disorder Rehabilitation Treatment benefits, including Preauthorization review, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for your Inpatient Hospital admissions and/or Outpatient services for the treatment of Mental Illness and Substance Use Disorder. The Mental Health Unit has staff which includes Physicians, Psychologists, Clinical Social Workers and registered nurses.

Failure to contact the Mental Health Unit or to comply with the determinations of the Mental Health Unit may result in a reduction of benefits. The Mental Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Behavioral Health Practitioner or Provider of services must comply with the guidelines below. Failure to Preauthorize services will require additional steps and/or benefit reductions as described in the provision entitled FAILURE TO PREAUTHORIZE OR NOTIFY.

PREAUTHORIZATION REVIEW

- **Inpatient Hospital Preauthorization Review**

Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate, if any.

In order to receive maximum benefits under this Certificate, you must Preauthorize your nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Use Disorder by calling the Mental Health Unit. Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one business day prior to the Inpatient Hospital admission.

- **Emergency Mental Illness or Substance Use Disorder Admission Review**

Emergency Mental Illness or Substance Use Disorder Admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate, if any.

In order to receive maximum benefits under this Certificate, you or someone on your behalf must notify the Mental Health Unit no later than two business days or as soon as reasonably possible after the admission for

the treatment of Mental Illness or Substance Use Disorder has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits. Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

- **Partial Hospitalization Treatment Program Preauthorization Review**

Partial Hospitalization Treatment Program Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate, if any.

In order to receive maximum benefits under this Certificate, you must Preauthorize your treatment of Mental Illness or Substance Use Disorder Rehabilitation Treatment by calling the Mental Health Unit. Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one business day prior to the scheduling of the Partial Hospitalization Treatment Program. The Mental Health Unit will obtain information regarding the service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

If an Inpatient Emergency Mental Illness or Substance Use Disorder Admission occurs after Outpatient service(s), in order to receive maximum benefits under this Certificate, an additional call must be made to the Mental Health Unit for an Emergency Mental Illness or Substance Use Disorder Admission Review.

- **Length of Stay/Service Review**

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate, if any.

Upon completion of the Preauthorization or Emergency Mental Illness or Substance Use Disorder Review, the Mental Health Unit will send you a letter confirming that you or your representative called the Mental Health Unit. A letter assigning a length of service or length of stay will be sent to your Behavioral Health Practitioner and/or the Hospital.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. In the event that the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to a Mental Health Unit Physician for review.

OUTPATIENT SERVICE PREAUTHORIZATION REVIEW**• Outpatient Service Preauthorization Review**

Outpatient service Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate, if any.

In order to receive maximum benefits under this Certificate for Outpatient services for the treatment of Mental Illness or Substance Use Disorder, you must Preauthorize the following Outpatient service(s) by calling the Mental Health Unit:

- Psychological testing
- Neuropsychological testing
- Electroconvulsive therapy
- Intensive Outpatient Programs

Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one business day prior to the scheduling of the planned Outpatient service. The Mental Health Unit will obtain information regarding the Outpatient service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

If an Inpatient Emergency Mental Illness or Substance Use Disorder Admission occurs after an Outpatient service, in order to receive maximum benefits under this Certificate, an additional call must be made to the Mental Health Unit for an Emergency Mental Illness or Substance Use Disorder Admission Review.

MEDICALLY NECESSARY DETERMINATION

If the Inpatient Hospital admission, Outpatient service, or other health care service or supply does not meet the criteria for Medically Necessary care, some days, services or the entire hospitalization will be denied and Blue Cross and Blue Shield will not be responsible for any related Hospital or other health care service or supply charge incurred. Your Behavioral Health Practitioner and in the case of an Inpatient Hospital admissions, the Hospital will be advised by telephone of this determination, with a follow-up notification letter sent to you, your Behavioral Health Practitioner and the Hospital, and will specify the dates, services or supplies that are not considered Medically Necessary. The Mental Health Unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission or service. For further details regarding Medically Necessary care and other exclusions from coverage under this Certificate, see the provision entitled, "EXCLUSIONS—WHAT IS NOT COVERED."

The Mental Health Unit does not determine your course of treatment or whether you receive particular health care services. The decision regarding

the course of treatment and receipt of particular health care services is a matter entirely between you and your Behavioral Health Practitioner. Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization, Outpatient service, or other health care service or supply is Medically Necessary under this Certificate.

Remember that your Blue Cross and Blue Shield Certificate does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Behavioral Health Practitioner or another health care Provider may prescribe, order, recommend or approve an Inpatient Hospital admission, Outpatient service, or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Behavioral Health Practitioner prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, Blue Cross and Blue Shield will not pay for the hospitalization, services or supplies if the Mental Health Unit Physician determines they were not Medically Necessary.

MENTAL HEALTH UNIT PROCEDURE

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission, Outpatient service, and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review you should be prepared to provide the following information:

1. the name of the attending and/or admitting Behavioral Health Practitioner;
2. the name of the Hospital or facility where the admission and/or service has been scheduled, when applicable;
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission, Outpatient service, and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review, the Mental Health Unit:

1. will review the medical information provided and follow-up with the Behavioral Health Practitioner;
2. may advise as to what Blue Cross and Blue Shield would consider as Medically Necessary.

APPEAL PROCEDURE

Expedited Appeal

If you or your Behavioral Health Practitioner disagree with the determinations of the Mental Health Unit prior to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Mental Health Unit and requesting an expedited appeal. The Mental Health Unit

Physician will review your case. You and/or your Behavioral Health Practitioner will be notified of the Mental Health Unit Physician's determination within twenty-four (24) hours or no later than the last authorized day. If you or your Behavioral Health Practitioner still disagree with the Mental Health Unit Physician, you may request an appeal in writing as outlined below.

Written Appeal

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after Claim processing has taken place or upon receipt of the notification letter from the Mental Health Unit, you may appeal that decision by having your Behavioral Health Practitioner call the contact person indicated in the notification letter or by submitting a written request to:

Blue Cross and Blue Shield of Illinois
Appeals Coordinator
Blue Cross and Blue Shield BH Unit
P. O. Box 660240
Dallas, TX 75266-0240
Fax Number: 1-877-361-7656

You must exercise the right to this appeal as a precondition to taking any action against Blue Cross and Blue Shield, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to Blue Cross and Blue Shield as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may review any relevant documents held by Blue Cross and Blue Shield, if you request an appointment in writing.

Within 30 days of receiving your request for review, Blue Cross and Blue Shield will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period. Depending on your situation, you may also request a claim review as described in the, "Claim Appeal Procedures" section in the HOW TO FILE A CLAIM section of this Certificate.

FAILURE TO PREAUTHORIZE OR NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Mental Health Unit will not interfere with your relationship with any Behavioral Health Practitioner. However, the Mental Health Unit has been established for the specific purpose of assisting you in maximizing your benefits provided under this Certificate.

Should you fail to Preauthorize or notify the Mental Health Unit as required in the Preauthorization Review provision of this section, you will then be responsible for the first \$1,000 or 50%, whichever is less, of the Hospital charges for an eligible Hospital stay in addition to any deductibles, Copayments and/or Coinsurance applicable to this Certificate. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this

Certificate nor can it be applied to your out-of-pocket expense limit, if applicable to this Certificate.

INDIVIDUAL BENEFITS MANAGEMENT PROGRAM ("IBMP")

In addition to the benefits described in this Certificate, if your condition would otherwise require continued care in a Hospital or other health care facility, provision of alternative benefits for services rendered by a Participating Provider in accordance with an alternative treatment plan may be available to you.

Alternative benefits will be provided only so long as they are Medically Necessary and cost effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under this Certificate.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations or exclusions of this Certificate.

MEDICARE ELIGIBLE MEMBERS

The provisions of the BLUE CROSS AND BLUE SHIELD MENTAL HEALTH UNIT section do not apply to you if you are Medicare Eligible and have secondary coverage provided under this Certificate.

THE PARTICIPATING PROVIDER OPTION

Your employer has chosen Blue Cross and Blue Shield's Participating Provider Option for the administration of your Hospital and Physician benefits and all other Covered Services. The Participating Provider Option is a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

As a participant in the Participating Provider Option a directory of Participating Providers is available to you. You can visit the Blue Cross and Blue Shield of Illinois Web site at www.bcbsil.com for a list of Participating Providers. While there may be changes in the directory from time to time, selection of Participating Providers by Blue Cross and Blue Shield will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided to your Group Administrator annually, or as otherwise required, to allow you to make selection within the network. However, you are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Participating Provider.

Before reading the description of your benefits, you should understand the terms "Benefit Period" and "Deductible" as defined below.

YOUR BENEFIT PERIOD

Your benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first December 31st following that date.

YOUR DEDUCTIBLE

Each benefit period you must satisfy the deductible amount(s) specified in the Benefit Highlights of this Certificate for Covered Services. In other words, after you have Claims for Covered Services for more than the deductible amount in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.

Each time you are admitted to a Hospital or Non-Plan Hospital, you must satisfy the Inpatient deductible amount (if applicable) specified in the Benefit Highlights of this Certificate. This deductible is in addition to your program deductible.

Each time you receive Covered Services for Outpatient Surgery in a Hospital or Non-Plan Hospital, you must satisfy the Outpatient Surgical deductible amount (if applicable) specified in the Benefit Highlights of this Certificate. This deductible is in addition to your program deductible.

If you have Family Coverage and your family has satisfied the family deductible amount specified in the Benefit Highlights of this Certificate, it will not be necessary for anyone else in your family to meet a program deductible in that benefit period. That is, for the remainder of that benefit period, no other family

members will be required to meet the program deductible before receiving benefits.

Should the federal government adjust the deductible(s) and/or out-of-pocket expense limit amount(s) applicable to this type of coverage, the deductible and/or the out-of-pocket expense limit amount(s) in this Certificate will be adjusted accordingly.

In any case, should two or more members of your family ever receive Covered Services as a result of injuries received in the same accident, only one program deductible will be applied against those Covered Services.

When your Group initially purchased this coverage, if you were a member of the Group at that time you are entitled to a special credit toward your Participating Provider program deductible for the first benefit period. This special credit applies to eligible expenses incurred for Covered Services within the prior contract's benefit period, if not completed. Such expenses can be applied toward the Participating Provider program deductible for the first benefit period under this coverage. However, this is only true if your Group had "major medical" type coverage immediately prior to purchasing this coverage.

HOSPITAL BENEFIT SECTION

Expenses for Hospital care are usually the biggest of all health care costs. Your Hospital benefits will help ease the financial burden of these expensive services. This section of your Certificate tells you what Hospital services are covered and how much will be paid for each of these services.

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

The level of benefits paid for Hospital Covered Services is generally greater when received in a Plan Hospital or other Plan facility.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

INPATIENT CARE

The following are Covered Services when you receive them as an Inpatient in a Hospital.

Inpatient Covered Services

1. Bed, Board and General Nursing Care when you are in:
 - a semi-private room
 - a private room
 - an intensive care unit
2. Ancillary Services (such as operating rooms, drugs, surgical dressings and lab work)

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery.

These tests are considered part of your Inpatient Hospital surgical stay.

Partial Hospitalization Treatment Program

Benefits are available for this program only if it is a Blue Cross and Blue Shield approved program. Covered Services rendered in a Non-Plan Provider facility will be paid at the Non-Participating Provider facility payment level. No bene-

fits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by Blue Cross and Blue Shield.

Coordinated Home Care Program

Benefits will be provided for services under a Coordinated Home Care Program.

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

Participating Provider

When you receive Inpatient Covered Services from a Participating Provider or in a Plan Program of a Participating Provider, benefits will be provided at the Participating Provider Inpatient Hospital payment level specified in the Benefit Highlights of this Certificate after you have met your program deductible and your Inpatient Hospital admission deductible, unless otherwise specified in this Certificate. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Participating Provider

When you receive Inpatient Covered Services from a Non-Participating Provider or in a Plan Program of a Non-Participating Provider, benefits will be provided at the Non-Participating Provider Inpatient Hospital payment level specified in the Benefit Highlights of this Certificate after you have met your program deductible and your Inpatient Hospital admission deductible, unless otherwise specified in this Certificate. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Plan Provider

When you receive Inpatient Covered Services from a Non-Plan Provider, benefits will be provided at the Non-Plan Provider payment level specified in the Benefit Highlights of this Certificate after you have met your program deductible and your Inpatient Hospital admission deductible.

Benefits for an Inpatient Hospital admission to a Non-Plan or Non-Participating Provider resulting from Emergency Accident Care or Emergency Medical Care will be provided at the same payment level which you would have received had you been in a Participating Hospital for that portion of your Inpatient Hospital stay during which your Medically Necessary condition is determined to be serious and therefore not permitting your safe transfer to a Participating Hospital or other Participating Provider.

Benefits for an Inpatient Hospital admission to a Non-Plan or Non-Participating Hospital resulting from Emergency Accident Care or Emergency Medical Care will be provided at the Non-Participating Hospital payment level or the Non-Plan Hospital payment level (depending on the type of Provider) for that portion of your Inpatient Hospital stay during which your Medically Necessary

condition is determined as not being serious and therefore permitting your safe transfer to a Participating Hospital or other Participating Provider.

In order for you to continue to receive benefits at the Participating Provider payment level following an emergency admission to a Non-Plan or Non-Participating Hospital, you must transfer to a Participating Provider as soon as your condition is no longer serious.

OUTPATIENT HOSPITAL CARE

The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services

1. Surgery and any related Diagnostic Service received on the same day as the Surgery
2. Radiation Therapy Treatments
3. Chemotherapy
4. Electroconvulsive Therapy
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care
7. Urgent Care
8. Emergency Accident Care
9. Emergency Medical Care
10. Mammograms—Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. Benefits for mammograms, other than routine, will be provided at the same payment level as Outpatient Diagnostic Service.
11. Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.
12. Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.
13. Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination. Unless otherwise stated, benefits will be provided at the benefit payment level described in the sec-

tion entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

14. Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.
15. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

Participating Provider

Benefits will be provided at the Participating Provider Outpatient Hospital payment level specified in the Benefit Highlights of this Certificate after you have met your program deductible and any applicable Outpatient Surgery deductible when you receive Outpatient Hospital Covered Services from a Participating Provider, unless otherwise specified in this Certificate.

Non-Participating Provider

When you receive Outpatient Hospital Covered Services from a Non-Participating Provider, benefits will be provided at the Non-Participating Provider Outpatient Hospital payment level specified in the Benefit Highlights of this Certificate after you have met your program deductible and any applicable Outpatient Surgery deductible, unless otherwise specified in this Certificate.

Non-Plan Provider

When you receive Outpatient Hospital Covered Services from a Non-Plan Provider, benefits will be provided at the Non-Plan Provider payment level specified in the Benefit Highlights of this Certificate after you have met your program deductible and any applicable Outpatient Surgery deductible. Covered Services received for Emergency Accident Care and Emergency Medical Care from a Non-Plan Provider will be paid at the same payment level which would have been paid had such services been received from a Participating Provider.

Emergency Care

Benefits for Emergency Accident Care will be provided at the Emergency Accident Care payment level specified in the Benefit Highlights of this Certificate

when you receive Covered Services from either a Participating, Non-Participating or Non-Plan Provider.

Benefits for Emergency Accident Care will not be subject to the program deductible.

Benefits for Emergency Medical Care will be provided at the Emergency Medical Care payment level specified in the Benefit Highlights of this Certificate when you receive Covered Services from either a Participating, Non-Participating or Non-Plan Provider.

Benefits for Emergency Medical Care will not be subject to the program deductible.

Each time you receive Covered Services in an emergency room, you may be responsible for an emergency room Copayment (if applicable) specified in the Benefit Highlights in this Certificate. If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room Copayment will be waived.

However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge whether or not you have met your program deductible. The emergency room Copayment will not apply.

This Copayment amount is subject to change or increase as permitted by applicable law.

WHEN SERVICES ARE NOT AVAILABLE FROM A PARTICIPATING PROVIDER (HOSPITAL)

If you must receive Medically Necessary Hospital Covered Services which are determined to be unavailable from a Participating Provider, benefits for the Covered Services you receive from a Non-Participating Provider will be provided at the payment level described for a Participating Provider.

PHYSICIAN BENEFITS SECTION

This section of your Certificate tells you what services are covered and how much will be paid when you receive care from a Physician or other specified Professional Provider.

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available, under this Benefit Section, services must be Medically Necessary and you must receive such services on or after your Coverage Date.

Remember, whenever the term “you” or “your” is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Surgery

Benefits are available for Surgery performed by a Physician, Dentist or Podiatrist. However, for services performed by a Dentist or Podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under this Certificate had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

1. surgical removal of complete bony impacted teeth;
2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

1. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for Anesthesia Services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon’s office or Ambulatory Surgical Facility.

In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.
3. Sterilization Procedures (even if they are elective)

Additional Surgical Opinion

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Claim Charge. Your program deductible will not apply to this benefit. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

Medical Care

Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital, a Substance Use Disorder Treatment Facility, or a Skilled Nursing Facility or
2. you are a patient in a Partial Hospitalization Treatment Program or a Co-ordinated Home Care Program or
3. you visit your Physician's office or your Physician comes to your home.

Consultations

Your coverage includes benefits for consultations. The consultation must be requested by your Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who also renders Surgery or Maternity Service during the same admission.

Diabetes Self-Management Training and Education

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professional with expertise in diabetes management. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this Certificate. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

Allergy Injections and Allergy Testing**Chemotherapy****Occupational Therapy**

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits will also be provided for preventive or Maintenance Physical Therapy when prescribed for persons affected by multiple sclerosis.

Radiation Therapy Treatments**Electroconvulsive Therapy****Speech Therapy**

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.

Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician.

Breast Cancer Pain Medication and Therapy—Benefits will be provided for all Medically Necessary pain medication and therapy related to the treatment of breast cancer. Pain therapy means therapy that is medically based and includes reasonably defined goals, including, but not limited to stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals. Benefits will also be provided for all Medically Necessary pain medication related to the treatment of breast cancer under the Prescription Drug section of this policy.

Diagnostic Service—Benefits will be provided for those services related to covered Surgery or Medical Care.

Mammograms—Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. Benefits for mammograms, other than routine, will be provided at the same payment level as Outpatient Diagnostic Service.

Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

Human Papillomavirus Vaccine—Benefits will be provided for a human papillomavirus (HPV) vaccine approved by the federal Food and Drug Administration. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. If you purchase the vaccine at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this Certificate.

Shingles Vaccine—Benefits will be provided for a shingles vaccine approved by the federal Food and Drug Administration.

Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis. Unless otherwise stated, benefits will be provided at the benefit payment level

described in the section entitled, "preventive care services" in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

Investigational Treatment—Benefits will be provided for routine patient care in conjunction with investigational treatments when medically appropriate and you have a terminal condition that according to the diagnosis of your Physician is considered life threatening, if a) you are a qualified individual participating in an Approved Clinical Trial program; and b) if those services or supplies would otherwise be covered under this Certificate if not provided in connection with an Approved Clinical Trial program. You and your Physician are encouraged to call customer service at the toll-free number on your identification card in advance to obtain information about whether a particular clinical trial is qualified.

Emergency Accident Care

Emergency Medical Care

Chiropractic and Osteopathic Manipulation—Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Your benefits for chiropractic and osteopathic manipulation will be limited to a maximum of 25 visits per benefit period.

Durable Medical Equipment—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates and any other internal and permanent devices. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

Prosthetic Appliances

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

1. they are required to replace all or part of an organ or tissue of the human body, or
2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required).

Orthotic Devices

Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary.

Outpatient Contraceptive Services

Benefits will be provided for prescription contraceptive devices, injections, implants and Outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, “preventive care services” in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

Amino Acid-Based Elemental Formulas—Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is medically necessary. If you purchase the formula at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this Certificate.

Routine Pediatric Hearing Examination—Benefits will be provided for routine hearing examinations.

Pulmonary Rehabilitation Therapy—Benefits will be provided for outpatient cardiac/pulmonary rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services.

Massage Therapy

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

The benefits provided by Blue Cross and Blue Shield and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Professional Provider.

Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist, benefits will be provided at the Participating Provider payment level for Surgical/Medical Covered Services specified in the Benefit Highlights of this Certificate after you have met your program deductible, unless otherwise specified in this Certificate. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this Certificate and may bill

you for the difference between the Blue Cross and Blue Shield benefit payment and the Provider's charge to you.

When you receive Covered Services (except for those services specified below) in a Participating Provider's office (other than a specialist's office), benefits for Covered Services, including all related Covered Services received on the same day, are subject to the Physician's office Copayment amount (if applicable) specified in the Benefit Highlights of this Certificate. Benefits will then be provided at the Physician's office payment level specified in the Benefit Highlights of this Certificate. Your program deductible will not apply.

When you receive Covered Services (except for those services specified below) in a Participating Provider specialist's office, benefits for Covered Services, including all related Covered Services received on the same day, are subject to the Participating Provider's specialist office Copayment amount (if applicable) specified in the Benefit Highlights of this Certificate. Benefits will then be provided at the specialist's office payment level specified in the Benefit Highlights of this Certificate. Your program deductible will not apply.

Benefits for certain Diagnostic tests may require a Copayment amount specified in the Benefit Highlights section of this Certificate. Your program deductible will not apply.

This Copayment amount is subject to change or increase as permitted by applicable law.

A specialist is a Provider who is **not** a:

- Behavioral Health Practitioner
- Certified Nurse-Midwife
- Certified Nurse Practitioner
- Certified Clinical Nurse Specialist
- Clinical Professional Counselor
- Clinical Social Worker
- Clinical Laboratory
- Marriage and Family Therapist
- Mixed psychiatric group
- Mixed specialty group
- Neuro Psychologist
- Optician
- Optometrist
- Retail Health Clinic

or a Physician in:

- clinical psychology
- family practice

- general practice
- gynecology
- internal medicine
- obstetrics
- obstetrics/gynecology
- pediatrics
- psychiatry

The following Covered Services are not subject to the office visit Copayment, and benefits will be provided at the general medical/surgical payment level, unless otherwise specified in this Certificate:

- Surgery
- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Chiropractic and osteopathic manipulation

Non-Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Non-Participating Provider, benefits will be provided at the Non-Participating Provider payment level for Surgical/Medical Covered Services specified in the Benefit Highlights of this Certificate after you have met your program deductible, unless otherwise specified in this Certificate.

Emergency Care

Benefits for Emergency Accident Care will be provided at the Emergency Accident Care payment level specified in the Benefit Highlights of this Certificate when rendered by either a Participating or Non-Participating Provider. Your program deductible will not apply.

Benefits for Emergency Medical Care will be provided at the Emergency Medical Care payment level specified in the Benefit Highlights of this Certificate when rendered by either a Participating or Non-Participating Provider. Your program deductible will not apply.

However, Covered Services for Emergency Accident Care and Emergency Medical Care resulting from a criminal sexual assault or abuse will be paid at 100% of the Maximum Allowance whether or not you have met your program deductible. The office visit Copayment will not apply.

This Copayment amount is subject to change or increase as permitted by applicable law.

Participating Providers are:

- Physicians

- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists

who have signed an Agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Blue Cross and Blue Shield benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Nurse-Midwives
- Certified Nurse Practitioners

- Certified Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists
- other Professional Providers

who have not signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Blue Cross and Blue Shield benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Group Administrator, your Professional Provider or Blue Cross and Blue Shield.

OTHER COVERED SERVICES

This section of your Certificate describes “Other Covered Services” and the benefits that will be provided for them.

- The processing, transporting, storing, handling and administration of blood and blood components.
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.
- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- Oxygen and its administration
- Medical and surgical dressings, supplies, casts and splints
- Naprapathic Service—Benefits will be provided for Naprapathic Services when rendered by a Naprapath. Benefits for Naprapathic Services will be limited to a maximum of 15 visits per benefit period.
- Hearing Aids—Benefits will be provided bone anchored hearing aids.
- Hearing Aids—Benefits will be provided for hearing aids for children limited to two every 36 months.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

Benefits will be provided at the Other Covered Services payment level specified in the Benefit Highlights of this Certificate of the Participating Provider amount set by the plan, regardless of whether the Provider is a Participating Provider or Non-Participating Provider with the Plan, after you have met your program deductible for any of the Covered Services described in this section.

When you receive Other Covered Services from a Participating or Non-Participating Provider, benefits for Other Covered Services will be provided at the payment levels previously described in this Certificate for Hospital and Physician Covered Services.

Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists

who have signed an Agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Blue Cross and Blue Shield benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists

- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists
- other Professional Providers

who have not signed an agreement with Blue Cross and Blue Shield to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Blue Cross and Blue Shield benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Group Administrator, your Professional Provider or Blue Cross and Blue Shield.

SPECIAL CONDITIONS AND PAYMENTS

There are some special things that you should know about your benefits should you receive any of the following types of treatments:

HUMAN ORGAN TRANSPLANTS

Your benefits for Medically Necessary human organ transplants are the same as your benefits for any other condition. Benefits are available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have Blue Cross and Blue Shield coverage each will have their benefits paid by their own Blue Cross and Blue Shield program.
- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this Certificate will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.
- If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this Certificate will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant Surgery.
- the evaluation, preparation and delivery of the donor organ.
- the removal of the organ from the donor.
- the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:

- **Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact Blue Cross and Blue Shield by telephone before your transplant Surgery has been scheduled. Blue Cross and Blue Shield will furnish you with the names of Hospitals which have Blue Cross and Blue Shield approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any Hospital that does not have a Blue Cross and Blue Shield approved Human Organ Transplant Coverage Program.**
- If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this Certificate, benefits for transportation and lodging will be provided for the transplant

recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.

- Benefits for transportation and lodging are limited to a combined maximum of \$10,000 per transplant. The maximum amount that will be provided for lodging is \$50 per person per day.
- In addition to the other exclusions of this Certificate, benefits will not be provided for the following:
- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
 - Travel time and related expenses required by a Provider.
 - Drugs which do not have approval of the Food and Drug Administration.
 - Storage fees.
 - Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.
 - Meals.

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Blue Cross and Blue Shield approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization.

PREVENTIVE CARE SERVICES

In addition to the benefits otherwise provided for in this Certificate, (and notwithstanding anything in your Certificate to the contrary), the following benefits for preventive care services will be considered Covered Services and will not be subject to any deductible, Coinsurance, Copayment or dollar maximum when such services are received from a Participating Provider or Participating Pharmacy that is contracted for such service:

- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);
- immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;
- Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Ser-

vices Administration (“HRSA”) for infants, children, and adolescents; and

- with respect to women, such additional preventive care and screenings, not described above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this preventive care services benefit provision, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The preventive care services described above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the website at www.bcbsil.com or contact customer service at the toll-free number on your identification card.

If a recommendation or guideline for a particular preventive health service does not specify the frequency, method, treatment or setting in which it must be provided, the Plan may use reasonable medical management techniques to determine coverage.

If a covered preventive health service is provided during an office visit and is billed separately from the office visit, you may be responsible for the Copayment or Coinsurance for the office visit only. If an office visit and the preventive health service are billed together and the primary purpose of the visit was not the preventive health service, you may be responsible for the Copayment or Coinsurance for the office visit including the preventive health service.

Preventive Care Services for Adults:

1. Abdominal aortic aneurysm screening for men who have ever smoked
2. Alcohol misuse screening and counseling
3. Aspirin use for men and women of certain ages
4. Blood pressure screening
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal cancer screening for adults over age 50
7. Depression screening
8. Type 2 diabetes screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. HIV screening for all adults at higher risk
11. The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
 - Hepatitis A
 - Hepatitis B
 - Hepatitis B
 - Herpes Zoster

- Human papillomavirus
 - Influenza (Flu shot)
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Tetanus, Diphtheria, Pertussis
 - Varicella
12. Obesity screening and counseling
 13. Sexually transmitted infections (STI) prevention
 14. Tobacco use screening and cessation interventions for tobacco users
 15. Syphilis screening for adults at higher risk

Preventive Care Services for Women (including pregnant women):

1. Anemia screening on a routine basis for pregnant women
2. Bacteriuria urinary tract screening or other infection screening for pregnant women
3. BRCA counseling about genetic testing for women at higher risk
4. Breast cancer chemoprevention counseling for women at higher risk
5. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
6. Cervical cancer screening for sexually active women
7. Chlamydia infection screening for younger women and women at higher risk
8. Contraception: FDA approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
9. Domestic and interpersonal violence screening and counseling for all women
10. Folic acid supplements for women who may become pregnant
11. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
12. Gonorrhea screening for all women at higher risk
13. Hepatitis B screening for pregnant women at their first prenatal visit
14. HIV screening and counseling for sexually active women
15. Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older
16. Osteoporosis screening for women over age 60, depending on risk factors
17. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk

18. Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
19. Sexually transmitted infections (STI) counseling for sexually active women
20. Syphilis screening for all pregnant women or other women at increased risk
21. Well woman visits to obtain recommended preventive services
22. Mammography for women at least every year for women ages 40 and over or at the age and intervals considered medically necessary by their Physician.

Preventive Care Services for Children:

1. Alcohol and drug use assessment for adolescents
2. Behavioral assessments for children of all ages
3. Blood pressure screenings for children of all ages
4. Cervical dysplasia screening for sexually active females
5. Congenital hypothyroidism screening for newborns
6. Depression screening for adolescents
7. Development screening for children under age 3, and surveillance throughout childhood
8. Dyslipidemia screening for children at higher risk of lipid disorder
9. Fluoride chemoprevention supplements for children without fluoride in their water source
10. Gonorrhea preventive medication for the eyes of all newborns
11. Hearing screening for all newborns
12. Height, weight and body mass index measurements
13. Hematocrit or hemoglobin screening
14. Hemoglobinopathies or sickle cell screening for all newborns
15. HIV screening for adolescents at higher risk
16. The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
 - Hepatitis A
 - Hepatitis B
 - Human papillomavirus
 - Influenza (Flu shot)
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Tetanus, Diphtheria, Pertussis
 - Varicella

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- Haemophilus influenzae type b
 - Rotavirus
 - Inactivated Poliovirus
 - any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.
17. Iron supplements for children ages 6 to 12 months at risk for anemia
 18. Lead screening for children at risk for exposure
 19. Medical history for all children throughout development
 20. Obesity screening and counseling
 21. Oral health risk assessment for younger children up to ten years old
 22. Phenylketonuria (PKU) screening for newborns
 23. Sexually transmitted infections (STI) prevention and counseling for adolescents at higher risk
 24. Tuberculin testing for children at higher risk of tuberculosis
 25. Vision screening for all children
 26. Autism screening, provided without regard to the Covered Person's age

The FDA approved contraceptive drugs and devices currently covered under this benefit provision are listed on the Contraceptive Drugs & Devices List. This list is available on our website at www.bcbsil.com and by contacting Customer Service at the toll-free number on your Identification Card. Benefits are not available under this benefit provision for Contraceptive drugs and devices not listed on the Contraceptive Drugs & Devices List. You may, however, have coverage under other sections of this Certificate, subject to any applicable Coinsurance, Copayments, deductibles and/or benefit maximum. The Contraceptive Drugs & Devices List and the preventive care services covered under this benefit provision are subject to change as FDA guidelines, medical management and medical policies are modified.

Preventive care services received from a Non-Participating Provider, a Non-Plan Provider facility, or a Non-Participating Pharmacy or other routine Covered Services not provided for under this provision may be subject to the deductible, Coinsurance, Copayments and/or benefit maximum.

If your plan covers Well Child Care, Women's Preventive Care (such as contraceptives) and/or Wellness Care, Covered Services not included in items a. through d. above will be subject to deductible, Coinsurance, Copayment and/or dollar maximum, if applicable.

If a recommendation or guidance for a particular preventive health service does not specify frequency, method, treatment or setting in which it must be provided, Blue Cross and Blue Shield may use reasonable medical management techniques, including but not limited to those related to setting and medical appropriateness, to determine coverage.

If a covered preventive health service is provided during an office visit and is billed separately from the office visit, you may be responsible for Coinsurance,

deductible and/or Copayment Amounts for the office visit only. If an office visit and the preventive health service are billed together and not billed separately, and the primary purpose of the visit was not the preventive health service, you may be responsible for Coinsurance, deductible and/or Copayment Amounts for the office visit including the preventive health service.

SKILLED NURSING FACILITY CARE

The following are Covered Services when you receive them in a Skilled Nursing Facility:

1. Bed, board and general nursing care.
2. Ancillary services (such as drugs and surgical dressings or supplies).

No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.

Benefits for Covered Services rendered in a Plan Skilled Nursing Facility will be provided at the Participating Provider Inpatient Hospital payment level specified in the Benefit Highlights of this Certificate after you have met your program deductible.

Benefits for Covered Services rendered in a Non-Plan Skilled Nursing Facility will be provided at the Non-Plan Provider payment level specified in the Benefit Highlights of this Certificate, once you have met your program deductible. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.

AMBULATORY SURGICAL FACILITY

Benefits for all of the Covered Services previously described in this Certificate are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

Benefits for services rendered by a Plan Ambulatory Surgical Facility will be provided at the Participating Provider Outpatient Hospital payment level specified in the Benefit Highlights of this Certificate. Benefits for services by a Non-Plan Ambulatory Surgical Facility will be provided at the Non-Plan Provider payment level specified in the Benefit Highlights of this Certificate.

Benefits for Outpatient Surgery will be provided as stated above after you have met your program deductible or any applicable Outpatient deductible.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT

Benefits for all of the Covered Services described in this Certificate are available for Substance Use Disorder Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Use Disorder Treatment Facility. Inpatient benefits for these Covered Services will also be provided for Substance Use Disorder Rehabilitation Treatment in a Residential Treatment Center. Substance Use Disorder Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with Blue Cross and Blue Shield or in a

Non-Plan Provider facility will be paid at the Non-Participating Provider facility payment level.

DETOXIFICATION

Covered Services received for detoxification are not subject to the Substance Use Disorder treatment provisions specified above. Benefits for Covered Services received for detoxification will be provided under the HOSPITAL BENEFITS and PHYSICIAN BENEFITS section of this Certificate, the same as for any other condition.

MENTAL ILLNESS AND SUBSTANCE USE DISORDER SERVICES

Benefits for all of the Covered Services described in this Certificate are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder. Inpatient benefits for these Covered Services will also be provided for the diagnosis and/or treatment of Inpatient Mental Illness in a Residential Treatment Center. Treatment of a Mental Illness or Substance Use Disorder is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license. Covered Services rendered in a Non-Plan Provider facility will be paid at the Non-Participating Provider facility payment level.

BARIATRIC SURGERY

Benefits for Covered Services received for Bariatric Surgery will be provided under the HOSPITAL BENEFITS and PHYSICIAN BENEFITS section of this Certificate, the same as for any other condition.

AUTISM SPECTRUM DISORDER(S)

Your benefits for the diagnosis and treatment of Autism Spectrum Disorder(s) are the same as your benefits for any other condition and will be provided without regard to the Covered Person's age. Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder by (a) a Physician or a Psychologist who has determined that such care is medically necessary, or, (b) a certified, registered, or licensed health care professional with expertise in treating Autism Spectrum Disorder(s) and when such care is determined to be medically necessary and ordered by a Physician or a Psychologist:

- psychiatric care, including diagnostic services;
- psychological assessments and treatments;
- habilitative or rehabilitative treatments;
- therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in the following areas: a) self care and feeding, b) pragmatic, receptive and expressive language, c) cognitive functioning, d) applied behavior analysis (ABA), intervention and modification, e) motor planning and f) sensory processing.

HABILITATIVE SERVICES

Your benefits for Habilitative Services for persons with a Congenital, Genetic, or Early Acquired Disorder are the same as your benefits for any other condition if all of the following conditions are met:

1. A Physician has diagnosed the Congenital, Genetic, or Early Acquired Disorder; and
2. Treatment is administered by a licensed speech-language pathologist, Audiologist, Occupational Therapist, Physical Therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, Clinical Social Worker, or Psychologist upon the referral of a Physician; and
3. Treatment must be Medically Necessary and therapeutic and not Investigational.

MATERNITY SERVICE

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges, b) one routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery and c) one Inpatient hearing screening. (If the newborn child needs treatment for an illness, injury, congenital defect, birth abnormality or a premature birth, benefits will be available for that care from the moment of birth up to the first 31 days, thereafter, you must add the newborn child to your Family Coverage. You may apply for Family Coverage within 31 days of the date of the birth. Your Family Coverage will then be effective from the date of the birth.)

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from Blue Cross and Blue Shield for prescribing a length of stay less than 48 hours (or 96 hours). Such an earlier discharge may only be provided if there is coverage and availability of a post-discharge physician office visit or an in-home nurse visit to verify the condition of the infant in the first 48 hours after discharge.

INFERTILITY TREATMENT

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis and/or treatment of infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection.

Infertility means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. The one year requirement will be waived if your Physician determines that a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to Chemotherapy or radiation treatments; or, efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

Unprotected sexual intercourse means sexual union between a male and female without the use of any process, device or method that prevents conception including, but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

Benefits for treatments that include oocyte retrievals will be provided only when:

- You have been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that makes such treatment useless; and
- You have not undergone four completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals shall be covered.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure to transfer the oocytes or sperm to you. Associated donor medical expenses are also covered, including, but not limited to, physical examinations, laboratory screenings, psychological screenings and prescription drugs.

The maximum number of completed oocyte retrievals that are eligible for coverage under this Certificate in your lifetime is six. Following the final completed oocyte retrieval, benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to you. Thereafter, you will have no benefits for infertility treatment.

Special Limitations

Benefits will not be provided for the following:

1. Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from you will be covered if you choose to use a surrogate.
2. Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term.

3. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.
4. Non-medical costs of an egg or sperm donor.
5. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary or required by Blue Cross and Blue Shield.
6. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.
7. Infertility treatment rendered to your dependents under age 18.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

Benefits for all of the Covered Services previously described in this Certificate are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

ROUTINE MAMMOGRAMS

Benefits will be provided for routine mammograms for all women. A routine mammogram is an x-ray or digital examination of the breast for the presence of breast cancer, even if no symptoms are present. Benefits for routine mammograms will be provided as follows:

- one baseline mammogram
- an annual mammogram

Benefits for routine mammograms will be provided for women who have a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors at least every year for women ages 40 and over or at the age and intervals considered medically necessary by their Physician.

If a routine mammogram reveals heterogeneous or dense breast tissue, benefits will be provided for a comprehensive ultrasound screening of an entire breast or breasts, when determined to be medically necessary by your Physician.

Participating Provider

Benefits for routine mammograms will not be subject to any deductible, Coinsurance or Copayment when such services are received from a Participating Provider.

Non-Participating Provider

Benefits for routine mammograms when rendered by a Non-Participating Provider will be provided at the Non-Participating Provider Outpatient Hospital payment level specified in the Benefit Highlights of this Certificate.

Benefit Maximum

Benefits for routine mammograms will not be subject to any benefit period maximum or lifetime maximum.

MASTECTOMY-RELATED SERVICES

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are not limited to:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Inpatient care following a mastectomy for the length of time determined by your attending Physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within 48 hours after discharge; and
4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.
5. The removal of breast implants when the removal of the implants is a Medically Necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury is not considered cosmetic surgery.

PAYMENT PROVISIONS

Lifetime Maximum

The total dollar amount that will be available in benefits for you is unlimited subject to the separate dollar maximums for specific Covered Services described earlier in this Certificate.

Cumulative Benefit Maximums

All benefits payable under this Certificate are cumulative. Therefore, in calculating the benefit maximums payable for a particular Covered Service, Blue Cross and Blue Shield will include benefit payments under both this and/or any prior or subsequent Blue Cross and Blue Shield Certificate issued to you as an Eligible Person or a dependent of an Eligible Person under this Group.

OUT-OF-POCKET EXPENSE LIMIT

There are separate Out-of-Pocket Expense Limits applicable to Covered Services received from Participating Providers and Non-Participating Providers.

For Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals the out-of-pocket expense limit in the Benefit Highlights of this Certificate, any additional eligible Claims for Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Participating or Non-Plan Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Blue Cross and Blue Shield Mental Health Unit

If you have Family Coverage, each member of your family must satisfy the out-of-pocket expense limit.

For Non-Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals the out-of-pocket expense limit in the Benefit Highlights of this Certificate, any additional eligible Claims for Non-Participating Providers or Non-Plan Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the payments for Covered Services rendered by a Non-Participating Provider or Non-Plan Provider for which you are responsible after benefits have been provided

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- the Coinsurance resulting from Covered Services you may receive from a Participating Provider
- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Blue Cross and Blue Shield Mental Health Unit

If you have Family Coverage, each member of your family must satisfy the out-of-pocket expense limit.

This out-of-pocket expense limit amount is subject to change or increase as permitted by applicable law.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this Certificate is terminated, benefits will be provided for, and limited to, the Covered Services of this Certificate which are rendered by and regularly charged by a Hospital, Skilled Nursing Facility, Substance Use Disorder Treatment Facility, Partial Hospitalization Treatment Program or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.

PEDIATRIC VISION COVERAGE

Coverage for *Pediatric Vision Care* is made part of, and is in addition to any information you may have in your Blue Cross and Blue Shield of Illinois Certificate. Coverage for *Pediatric Vision Care* provides information about coverage for the routine vision care services outlined below, which are specifically excluded under your medical/surgical health care plan. **(Services that are covered under your medical/surgical Certificate are not covered under this *Pediatric Vision Care* benefit.) All provisions in the medical Certificate apply to coverage for *Pediatric Vision Care* unless specifically indicated otherwise below.**

This BCBSIL vision care plan allows members to select the provider of their choice, in or out of the Network. BCBSIL has designed benefit plans to deliver quality care, matched with comprehensive benefits, at the most affordable cost, through Network services. You also have the flexibility to visit an Out-of-Network Provider, with a reduction in benefits.

DEFINITIONS

Benefit Period—For purposes of *Pediatric Vision Care*, a period of time that begins on the later of:

1. the member's effective date of coverage, or
2. the last date a vision examination was performed on the member or that Vision Materials were provided to the member, whichever is applicable. (A benefit period does not coincide with a calendar year and may differ for each covered member of a group or family.)

Pediatric Frame Collection—A collection of frames that are covered under the Pediatric Vision Care benefit which includes adult sizes for members up to age 19.

Provider—For purposes of *Pediatric Vision Care*, a licensed ophthalmologist or optometrist operating within the scope of his or her license, or a dispensing optician.

Vision Materials—Corrective lenses and/or frames or contact lenses.

ELIGIBILITY

Children who are covered under a BCBSIL medical/surgical plan, through age 19, are eligible for coverage for *Pediatric Vision Care*. NOTE: Once coverage is lost under the medical/surgical plan, all benefits cease for *Pediatric Vision Care*. Extension of benefits due to disability, state or federal continuation coverage, and conversion option privileges are **not** available for *Pediatric Vision Care*.

LIMITATIONS AND EXCLUSIONS

In addition to the general limitations and exclusions listed in your medical/surgical certificate, *Pediatric Vision Care* does not cover services or materials connected with or charges arising from:

- Any vision service, treatment or materials not specifically listed as a covered service;
- Services and materials that are experimental or investigational;
- Services or materials which are rendered prior to your effective date;
- Services and materials incurred after the termination date of your coverage unless otherwise indicated;
- Services and materials not meeting accepted standards of optometric practice;
- Services and materials resulting from your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Services or materials provided as a result of intentionally self-inflicted injury or illness;
- Services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;
- Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts;
- State or territorial taxes on vision services performed;
- Medical treatment of eye disease or injury;
- Visual therapy;
- Special lens designs or coatings other than those described in this brochure;
- Replacement of lost/stolen eyewear;
- Non-prescription (Plano) lenses;
- Two pairs of eyeglasses in lieu of bifocals;
- Services not performed by licensed personnel;
- Prosthetic devices and services (*prosthetic devices and services are covered as a medical benefit and may be found in the PHYSICIAN BENEFIT SECTION of this Certificate*);
- Insurance of contact lenses;
- Professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption.

HOW THE VISION CARE PLAN WORKS

Under the vision care plan option, you may visit any covered provider and receive benefits for a vision examination. In order to maximize benefits for most covered Vision Materials, however, you must purchase them from a Network Provider.

Before you go to a Network vision care plan provider for an eye examination, eyeglasses, or contact lenses, please call ahead for an appointment. When you arrive, show the receptionist your Identification Card. If you forget to take your card, be sure to say that you are a member of the BCBSIL vision care plan so that your eligibility can be verified.

To locate a Network vision care provider, visit our website at **www.bcbsil.com**, or contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card to obtain a list of the Network vision care plan providers nearest you.

If you obtain glasses or contacts from an Out-of-Network provider, you must pay the provider in full and submit a claim for reimbursement (see **CLAIM FILING PROCEDURES** for more information).

You may receive your eye examination and eyeglasses/contacts on different dates or through different provider locations, if desired. However, complete eyeglasses must be obtained at one time, from one provider. Continuity of care will best be maintained when all available services are obtained at one time from one Network Provider and there may be additional professional charges if you seek contact lenses from a provider other than the one who performed your eye examination.

Fees charged for services other than a covered vision examination or covered Vision Materials, and amounts in excess of those payable for *Pediatric Vision Care*, must be paid in full by you to the provider, whether or not the provider participates in the vision care plan network. Benefits for *Pediatric Vision Care* may not be combined with any discount, promotional offering, or other group benefit plans. Allowances are one-time use benefits; no remaining balances are carried over to be used later.

HOSPICE CARE PROGRAM

Your Hospital coverage also includes benefits for Hospice Care Program Service.

Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

1. Coordinated Home Care;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services—Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services;
10. Respite Care Service.

The following services are **not** covered under the Hospice Care Program:

1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
5. Transportation, including, but not limited to, Ambulance Transportation.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this Certificate.

Benefit Payment for Hospice Care Program Services

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same level as described for Inpatient Hospital Covered Services.

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION

When you are being treated for an illness or accident, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage includes benefits for drugs and supplies which are self-administered. This Benefit Section of your Certificate explains which drugs and supplies are covered and the benefits that are available for them. Benefits will be provided only if such drugs and supplies are Medically Necessary.

Although you can go to the Pharmacy of your choice, your benefits for drugs and supplies will be greater when you obtain them from a Participating Pharmacy. You can visit the Blue Cross and Blue Shield Web site at www.bcbsil.com for a list of Participating Pharmacies or call the Customer Service toll-free number on your identification card. The Pharmacies that are Participating Pharmacies may change from time to time. You should check with your Pharmacy before obtaining drugs or supplies to make certain of its participation status.

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

NOTE: The use of an adjective such as Participating or Specialty in modifying a Pharmacy shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Pharmacy. In addition, the omission, non-use or non-designation of Participating or any similar modifier or the use of a term such as Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Pharmacy.

For purposes of this Benefit Section only, the following definitions shall apply:

AVERAGE WHOLESALE PRICE.....means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

BRAND NAME DRUG.....means a drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand Name Drug. There may also be situations where a drug's classification changes from Generic to Formulary or Non-Formulary Brand Name due to a change in the market resulting in the Generic Drug being a single source, or the drug product database information changing, which would also result in a corresponding change to your payment obligations from Generic to Formulary or Non-Formulary Brand Name.

COINSURANCE AMOUNT.....means the percentage amount paid by you for each Prescription Order filled or refilled through a Participating Pharmacy or Non-Participating Pharmacy.

COMPOUND DRUGS.....means those drugs or inert ingredients that have been measured and mixed with United States Food and Drug Administration (FDA)-approved pharmaceutical ingredients by a pharmacist to produce a unique formulation that is Medically Necessary because commercial products either do not exist or do not exist in the correct dosage, size, or form.

COPAYMENT AMOUNT.....means the dollar amount paid by you for each Prescription Order filled or refilled through a Participating Pharmacy or Non-Participating Pharmacy.

COVERED DRUGS.....means any Legend Drug (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, including disposable syringes and needles needed for self administration):

- (i) Which is Medically Necessary and is ordered by a Health Care Practitioner naming you as the recipient;
- (ii) For which a written or verbal Prescription Order is provided by a Health Care Practitioner;
- (iii) For which a separate charge is customarily made;
- (iv) Which is not entirely consumed or administered at the time and place that the Prescription Order is written;
- (v) For which the FDA has given approval for at least one indication; and
- (vi) Which is dispensed by a Pharmacy and is received by you while covered under this Benefit Section, **except when** received from a Provider's office, or during confinement while a patient in a Hospital or other acute care institution or facility (refer to the EXCLUSIONS provision later in this Benefit Section).

ELIGIBLE CHARGE.....means (a) in the case of a Provider which has a written agreement with a Blue Cross and Blue Shield Plan, or with the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, to provide Covered Services to you at the time you receive the Covered Services, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with a Blue Cross and Blue Shield Plan, or with the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, to provide services to you at the time you receive Covered Services, either of the following charges for Covered Services:

- (i) the charge which the particular Prescription Drug Provider usually charges for Covered Services, or

- (ii) the agreed upon cost between a Participating Pharmacy and a Blue Cross and Blue Shield Plan or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, whichever is lower.

FORMULARY BRAND NAME DRUG.....means a brand name prescription drug product that is identified on the *Formulary Drug List* and is subject to the Formulary Brand Name Drug payment level. The *Formulary Drug List* is available by accessing the Web site at www.bcbsil.com.

GENERIC DRUG.....means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Covered Drugs and corresponding payment level, Blue Cross and Blue Shield utilizes the generic/brand status assigned by a nationally recognized provider of drug product database information. A list of generic drugs is available by accessing the Web site at www.bcbsil.com. You may also contact a Customer Service Advocate for more information.

LEGEND DRUGS.....means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution — Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

MAINTENANCE DRUGS.....means drugs prescribed for chronic conditions and are taken on a regular basis to treat conditions such as high cholesterol, high blood pressure, or asthma.

NATIONAL DRUG CODE (NDC).....means a national classification system for the identification of drugs.

NON-FORMULARY BRAND NAME DRUG.....means a Brand Name Drug which does not appear on the *Formulary Drug List* and is subject to the Non-Formulary Brand Name Drug payment level. The *Formulary Drug List* is available by accessing the Web site at www.bcbsil.com.

NON-PARTICIPATING PHARMACY or NON-PARTICIPATING PRESCRIPTION DRUG PROVIDER.....means an independent retail Pharmacy, chain of retail Pharmacies, home delivery Pharmacy or specialty drug Pharmacy which has not entered into a written agreement with Blue Cross and Blue Shield, or with an entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, to provide pharmaceutical services to you at the time you receive the services.

PARTICIPATING PHARMACY or PARTICIPATING PRESCRIPTION DRUG PROVIDER.....means an independent retail Pharmacy, chain of retail Pharmacies, home delivery Pharmacy or specialty drug Pharmacy which has entered into a written agreement with Blue Cross and Blue Shield, or with an

entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, to provide pharmaceutical services to you at the time you receive the services.

PHARMACY.....means a state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

PRESCRIPTION ORDER.....means a written or verbal order from a Health Care Practitioner to a pharmacist for a drug to be dispensed. Orders written by a Health Care Practitioner located outside the United States to be dispensed in the United States are not covered under this Benefit Section.

SPECIALTY DRUGS.....means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected, but may also include drugs that are high cost oral medications and/or that have special storage requirements. In addition, patient support and/or education may be required for these drugs. The list of Specialty Drugs is subject to change. To determine which drugs are Specialty Drugs, you should contact your Pharmacy, refer to the *Formulary Drug List* by accessing the Web site at www.bcbsil.com or call the Customer Service toll-free number on your identification card.

SPECIALTY PHARMACY PROVIDER.....means a Participating Prescription Drug Provider that has a written agreement with Blue Cross and Blue Shield, or with the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program, to provide Specialty Drugs to you.

ABOUT YOUR BENEFITS

Formulary Drug List

Formulary drugs are selected by Blue Cross and Blue Shield based upon the recommendations of a committee, which is made up of current and previously practicing physicians and pharmacists from across the country, some of whom are employed by or affiliated with Blue Cross and Blue Shield. The committee considers drugs regulated by the FDA for inclusion on the formulary. As part of the process, the committee reviews data from clinical studies, published literature and opinions from experts who are not part of the committee. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost and how it compares with drugs currently on the formulary.

The committee considers drugs that are newly approved by the FDA, as well as those that have been on the market for some time. Entire drug classes are also regularly reviewed. Changes to this list can be made from time to time.

The *Formulary Drug List* and any modifications will be made available to you. Blue Cross and Blue Shield may offer multiple formularies. By accessing the Web site at www.bcbsil.com or calling the Customer Service toll-free number on your identification card, you will be able to determine the *Formulary Drug List*

that applies to you and whether a particular drug is on the *Formulary Drug List*. Drugs that do not appear on the *Formulary Drug List* are subject to the Non-Formulary Brand Name Drug payment level specified in the Benefit Highlights of this Certificate plus any pricing differences that may apply to the Covered Drug you receive.

Prior Authorization/Step Therapy Requirement

When certain medications and drug classes, such as medications used to treat rheumatoid arthritis, growth hormone deficiency, hepatitis C, and more serious forms of anemia, hypertension, epilepsy, and psoriasis are prescribed, your Physician will be required to obtain authorization from Blue Cross and Blue Shield in order for your medication to be eligible for benefits. Medications included in this program are subject to change and other medications for other conditions may be added to the program. Although you may currently be on therapy, your claim may need to be reviewed to see if the criteria for coverage of further treatment has been met. A documented treatment with a generic or brand therapeutic alternative medication may be required for continued coverage of the brand name medication.

Blue Cross and Blue Shield or its prescription drug administrator will send a questionnaire to your Physician upon your or your Pharmacy's request. The questionnaire must be returned to the prescription drug administrator who will review the questionnaire and determine whether the reason for the prescription meets the criteria for Medically Necessary care. You and your Physician will be notified of the prescription drug administrator's determination. Coverage will only be provided for Medically Necessary care. Although there is no penalty if you do not obtain authorization prior to purchasing the medication, you are strongly encouraged to do so, to help you and your doctor factor your cost into your treatment decision. If criteria for Medical Necessity is not met, coverage will be denied and you will be responsible for the full charge incurred.

To find out more about prior authorization/step therapy requirements or to determine which drugs or drug classes require prior authorization or step therapy, you should contact your Pharmacy or refer to the *Formulary Drug List* by accessing the Web site at www.bcbsil.com or call the Customer Service toll-free number on your identification card.

Dispensing Limits

If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by a Health Care Practitioner, coverage will only be provided for a clinically appropriate pre-determined maximum quantity of medication for the specified amount of time. Dispensing limits are based upon FDA dosing recommendations and nationally recognized clinical guidelines.

The maximum quantity of a given prescription drug means the number of units to be dispensed and is determined based on pertinent medical information and clinical efficacy and safety. Quantities of some drugs are restricted regardless of the quantity ordered by the Health Care Practitioner. To determine if a specific drug is subject to this limitation, you can refer to the *Formulary Drug List* by

accessing the Web site at www.bcbsil.com or call the Customer Service toll-free number on your identification card.

If you require a Prescription Order in excess of the dispensing limit established by Blue Cross and Blue Shield, ask your Health Care Practitioner to submit a request for clinical review on your behalf. The request will be approved or denied after evaluation of the submitted clinical information. Dispensing limits may change from time to time. Payment for benefits covered under this Benefit Section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum quantity limitation.

Day Supply

In order to be eligible for coverage under this Certificate, the prescribed day supply must be Medically Necessary and must not exceed the maximum day supply limitation described in this Certificate. Payment for benefits covered under this Benefit Section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation. Coverage for Specialty Drugs are limited to a 30 day supply.

Controlled Substances Limitation

If Blue Cross and Blue Shield determines that a Member may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized treatment guidelines, any coverage for additional drugs may be subject to a review for Medical Necessity, appropriateness and other coverage restrictions such as limiting coverage to prescription orders written by a certain Provider and/or dispensed by a certain Participating Pharmacy.

Extended Retail Prescription Drug Supply Program

Your coverage includes benefits for up to a 90 day supply of maintenance type drugs and diabetic supplies purchased from a Participating Prescription Drug Provider (which may only include retail or home delivery pharmacies). Benefit payment amounts are listed in the Benefit Highlight Section. The payment levels described in the Benefit Highlights of this Certificate are for a 30 day supply. To find a list of Pharmacies participating in this program, refer to the Web site at www.bcbsil.com.

Benefits will not be provided for a 90 supply drugs or diabetic supplies obtained from a Prescription Drug Provider not participating in the extended retail prescription drug supply program.

COVERED SERVICES

Benefits for Medically Necessary Covered Drugs prescribed to treat you for a chronic, disabling, or life-threatening illness are available if the drug:

1. Has been approved by the FDA for at least one indication; and
2. Is recognized by the following for treatment of the indication for which the drug is prescribed:

- a. a prescription drug reference compendium approved by the Department of Insurance, or
- b. substantially accepted peer-reviewed medical literature.

As new drugs are approved by the FDA, such drugs, unless the intended use is specifically excluded in this Benefit Section, are eligible for benefits. Some equivalent drugs are manufactured under multiple brand names. In such cases, Blue Cross and Blue Shield may limit benefits to only one of the brand equivalents available.

A separate Copayment Amount or Coinsurance Amount will apply to each fill of a medication having a unique strength, dosage, or dosage form.

Injectable Drugs

Benefits are available for Medically Necessary injectable drugs which are self-administered that require a written prescription by federal law. Benefits will not be provided for any self-administered drugs dispensed by a Physician.

Immunosuppressant Drugs

Benefits are available for Medically Necessary immunosuppressant drugs with a written prescription after an approved Human Organ Transplant.

Fertility Drugs

Benefits are available for Medically Necessary fertility drugs in connection with the diagnosis and/or treatment of infertility with a written prescription.

Diabetic Supplies for Treatment of Diabetes

Benefits are available for Medically Necessary items of diabetic supplies for which a Health Care Practitioner has written an order. Such diabetes supplies shall include, but are not limited to, the following:

- Test strips specified for use with a corresponding blood glucose monitor
- Glucose test solutions
- Glucagon
- Glucose tablets
- Lancets and lancet devices
- Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein
- Insulin and insulin analog preparations
- Injection aids, including devices used to assist with insulin injection and needleless systems
- Insulin syringes
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels

- Glucagon emergency kits

Vaccinations obtained through Participating Pharmacies

Benefits for vaccinations are available through certain Participating Pharmacies that have contracted with Blue Cross and Blue Shield to provide this service. To locate one of these contracting Participating Pharmacies in your area and to find out which vaccinations are covered, call the Customer Service toll-free number on your identification card or access the Web site at www.bcbsil.com. At the time you receive services, present your Blue Cross and Blue Shield identification card to the pharmacist. This will identify you as a participant in the Blue Cross and Blue Shield health care plan provided by your employer. The pharmacist will inform you of the amount for which you are responsible for, if any.

Each Participating Pharmacy that has contracted with Blue Cross and Blue Shield to provide this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance. Childhood immunizations subject to state regulations are not available under this Benefit Section. Refer to your Blue Cross and Blue Shield medical coverage for benefits available for childhood immunizations.

Benefits for vaccinations that are considered preventive care services will not be subject to any deductible, Coinsurance, Copayment or dollar maximum when such services are received from a Participating Provider or Participating Pharmacy that is contracted for such service.

Vaccinations that are received from a Non-Participating Provider, a Non-Plan Provider facility, or a Non-Participating Pharmacy or other routine Covered Services not provided for under this provision may be subject to the deductible, Coinsurance, Copayments and/or benefit maximum.

Self-Administered Cancer Medications

Benefits will be provided for self-administered cancer medications, including pain medication.

Breast Cancer Pain Medication and Therapy—Benefits will be provided for all Medically Necessary pain medication related to the treatment of breast cancer. Benefits will also be provided for all Medically Necessary pain therapy related to the treatment of breast cancer under the PHYSICIAN BENEFIT SECTION of this policy.

Cancer Medications

Benefits will be provided for orally administered cancer medications, intravenously administered cancer medications or injected cancer medications that are used to kill or slow the growth of cancerous cells. Your Copayment Amount or Coinsurance Amount or deductible will not apply to orally administered cancer medications.

Specialty Drugs

Benefits are available for Specialty Drugs as described under **Specialty Pharmacy Program**.

SELECTING A PHARMACY

Participating Pharmacy

When you choose to go to a Participating Pharmacy:

- present your identification card to the pharmacist along with your Prescription Order,
- provide the pharmacist with the birth date and relationship of the patient,
- pay the applicable deductible, if any, and
- pay the appropriate Copayment Amount or Coinsurance Amount for each Prescription Order filled or refilled and the pricing difference when it applies to the Covered Drug you receive.

Participating Pharmacies have agreed to accept as payment in full the least of:

- the billed charges, or
- the Eligible Charge, or
- the amount for which you are responsible for as described under the BENEFIT PAYMENT FOR PRESCRIPTION DRUGS provision later in this Benefit Section.

You may be required to pay for limited or non-Covered Services. No Claim forms are required if you follow the above procedures.

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may access the Web site at www.bcbsil.com or call the Customer Service toll-free number on your identification card.

Non-Participating Pharmacy

If you choose to have a Prescription Order filled at a Non-Participating Pharmacy, you must pay the Pharmacy the full amount of its bill and submit a Claim form to Blue Cross and Blue Shield or to the prescription drug administrator with itemized receipts verifying that the Prescription Order was filled. Blue Cross and Blue Shield will reimburse you for Covered Drugs equal to:

- the Coinsurance Amount indicated,
- the Copayment Amount indicated,
- less the amount for which you are responsible for as described under the BENEFIT PAYMENT FOR PRESCRIPTION DRUGS provision later in this Benefit Section.

Please refer to the provision entitled “Filing Outpatient Prescription Drug Claims” in the HOW TO FILE A CLAIM section of this Certificate.

Home Delivery Prescription Drug Program

The Home Delivery Prescription Drug Program provides delivery of Covered Drugs directly to your home address. In addition to the benefits described in this Benefit Section, your coverage includes benefits for Maintenance Drugs and diabetic supplies obtained through the Home Delivery Prescription Drug Program.

Some drugs may not be available through the Home Delivery Prescription Drug Program. For a listing of Maintenance Drugs or if you have any questions about the Home Delivery Prescription Drug Program, need assistance in determining the amount of your payment, or need to obtain the home delivery order form, you may access the Web site at www.bcbsil.com or call the Customer Service toll-free number on your identification card. Mail the completed form, your Prescription Order(s) and payment to the address indicated on the form.

If you send an incorrect payment amount for the Covered Drug dispensed, you will: (a) receive a credit if the payment is too much; or (b) be billed for the appropriate amount if it is not enough.

When you obtain Maintenance Drugs through the Home Delivery Prescription Drug Program, benefits will be provided according to the **Home Delivery Prescription Drug Program** payment provision described later in this Benefit Section.

For information about the Home Delivery Prescription Drug Program, contact your employer or group administrator.

Specialty Pharmacy Program

This program provides delivery of medications directly to your Health Care Practitioner, administration location or to your home if you are undergoing treatment for a complex medical condition. To determine which drugs are Specialty Drugs or to locate a Specialty Pharmacy Provider, you should refer to the *Formulary Drug List* by accessing the Web site at www.bcbsil.com or call the Customer Service toll-free number on your identification card.

The Specialty Pharmacy Program delivery service offers:

- Coordination of coverage between you, your Health Care Practitioner and Blue Cross and Blue Shield,
- Educational materials about the patient's particular condition and information about managing potential medication side effects,
- Syringes, sharp containers, alcohol swabs and other supplies with every shipment of FDA approved self-injectable medications, and
- Access to a pharmacist 24 hours a day, 7 days a week, 365 days each year.

In order to receive maximum benefits for Specialty Drugs, you must obtain the Specialty Drugs from the preferred Specialty Pharmacy Provider. When you obtain Specialty Drugs from the preferred Specialty Pharmacy Provider, benefits will be provided according to the payment provisions indicated in this Benefit Highlights of this Certificate.

YOUR COST

Deductible

If you are responsible for a Coinsurance Amount, each benefit period you must satisfy the Participating Provider program deductible described in the Benefit Highlights of this Certificate for your medical benefits before your benefits will begin for drugs and diabetic supplies. Expenses incurred by you for Covered Services under this Benefit Section will also be applied towards the program deductible.

BENEFIT PAYMENT FOR PRESCRIPTION DRUGS

Retail Pharmacy

The benefits you receive and the amount you pay will differ depending upon the type of drugs, or diabetic supplies or insulin and insulin syringes obtained and whether they are obtained from a Participating or Non-Participating Pharmacy.

When you obtain Covered Drugs including diabetic supplies from a Participating Pharmacy, benefits will be provided as shown in the Benefit Highlights section of this Certificate.

When you obtain Covered Drugs, including diabetic supplies from a Non-Participating Pharmacy (other than a Participating Pharmacy) you will be responsible for paying the full amount of the charge at the point of service and submitting your Claim as shown in the HOW TO FILE A CLAIM section of this Certificate. Upon receipt of your Claim, you will be reimbursed for benefits at 50% of the Eligible Charge and with any applicable Copayment Amount or Coinsurance Amount deducted from that amount.

One prescription means up to a 30 consecutive day supply of a drug. Certain drugs may be limited to less than a 30 consecutive day supply. However, for certain Maintenance Drugs, larger quantities may be obtained through the Home Delivery Prescription Drug Program. For information on these drugs, contact your Participating Pharmacy or call the Customer Service toll-free number on your identification card. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

Home Delivery Prescription Drug Program

When you obtain Covered Drugs through the Home Delivery Prescription Drug Program, benefits will be provided as shown in the Benefit Highlights section of this Certificate:

Under the Home Delivery Prescription Drug Program, one prescription means up to a 90 consecutive day supply of a drug. Certain drugs may be limited to less than a 90 consecutive day supply.

Specialty Pharmacy Program

When you obtain covered Specialty Drugs from a Provider who is not a Specialty Pharmacy Provider, 50% of the amount you would have received had you

obtained the Specialty Drugs from a Specialty Pharmacy Provider minus the Copayment Amount or Coinsurance Amount.

EXCLUSIONS

For purposes of this Benefit Section only, the following exclusions shall apply:

1. Drugs which do not by law require a Prescription Order from a Provider or Health Care Practitioner (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels); and drugs or covered devices for which no valid Prescription Order is obtained.
2. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order,) such as, but not limited to, male contraceptive devices, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as diabetes supplies).
3. Administration or injection of any drugs.
4. Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative).
5. Drugs dispensed in a Physician's or Health Care Practitioner's office or during confinement while as a patient in a Hospital, or other acute care institution or facility, including take-home drugs or samples; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
6. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
7. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery.
8. Drugs which are repackaged by a company other than the original manufacturer.
9. Drugs dispensed in quantities in excess of the day supply amounts stipulated in this Benefit Section, certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or Health Care Practitioner or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.
10. Legend Drugs which are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except for the treatment of certain types of cancer when a particular legend drug has been shown to be effective for the treatment of that specific type of cancer even though that legend drug has not been approved for that type of cancer. The drug must have been shown to be effective for the treatment of that particular cancer according to the Federal Secretary of Health and Human Services.
11. Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal

al (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically mentioned in this Certificate. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.

12. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
13. Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, or not Medically Necessary.
14. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card.
15. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your employer's group health care plan, or for which benefits have been exhausted.
16. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
17. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
18. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined by Blue Cross and Blue Shield.
19. Athletic performance enhancement drugs.
20. Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form, except when used to treat Medically Necessary Covered Services resulting from an organic disease or illness, injury or congenital defect.
21. Some equivalent drugs manufactured under multiple brand names. Blue Cross and Blue Shield may limit benefits to only one of the brand equivalents available.
22. Compound Drugs
23. Drugs without superior clinical efficacy which have lower cost therapeutic equivalents or therapeutic alternatives.
24. Medications in depot or long acting formulations that are intended for use longer than the covered days supply amount.

EXCLUSIONS—WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

- **Hospitalization, or health care services and supplies which are not Medically Necessary.**

No benefits will be provided for services which are not Medically Necessary as defined by this Certificate.

- Services or supplies that are not specifically mentioned in this Certificate.
- Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.
- Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
- Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.
- Services or supplies that do not meet accepted standards of medical and/or dental practice.
- Investigational Services and Supplies and all related services and supplies, except as may be provided under this Certificate for a) the cost of routine patient care associated with Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this Certificate if not provided in connection with a qualified clinical cancer trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).
- Custodial Care Service.
- Long Term Care Service.
- Respite Care Service, except as specifically mentioned under the Hospice Care Program.
- Inpatient Private Duty Nursing Service.

- Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Charges for failure to keep a scheduled visit or charges for completion of a Claim form.
- Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- Special braces, specialized equipment, appliances, ambulatory apparatus, except as specifically mentioned in this Certificate.
- Blood derivatives which are not classified as drugs in the official formularies.
- Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except for Pediatric Vision and as specifically mentioned in this Certificate.
- Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.
- Routine foot care, except for persons diagnosed with diabetes.
- Immunizations, unless otherwise specified in this Certificate.
- Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this Certificate.
- Maintenance Care.
- Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation, except as may be provided under this Certificate for Autism Spectrum Disorder(s).
- Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services, except as they relate to Autism Spectrum Disorder(s).

- Hearing aids, except for hearing aids for children or bone anchored hearing aids (osseointegrated auditory implants), examinations for the prescription or fitting of hearing aids, unless otherwise specified in this Certificate.
- Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are employees of the Group and each is covered separately under this Certificate.
- Diagnostic Service as part of premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational unless otherwise specified in this Certificate.
- Residential Treatment Centers, except for Inpatient Substance Use Disorder Rehabilitation Treatment or Inpatient Mental Illness and as specifically mentioned under this Certificate
- Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
- Wigs (also referred to as cranial prostheses), unless otherwise specified in this Certificate.
- Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Certificate.
- Abortions, including related services and supplies, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Repair and replacement for appliances and/or devices due to misuse or loss, except as specifically mentioned in this Certificate.
- Acupuncture, whether for medical or anesthesia purposes.

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies to this Benefit Program when you or your covered dependent has health care coverage under more than one Benefit Program. COB does not apply to the Outpatient Prescription Drug Program Benefit Section.

The order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this Benefit Program are determined before or after those of another Benefit Program. The benefits of this Benefit Program:

1. Shall not be reduced when, under the order of benefit determination rules, this Benefit Program determines its benefits before another Benefit Program; but
2. May be reduced when, under the order of benefits determination rules, another Benefit Program determines its benefits first. This reduction is described below in "When this Benefit Program is a Secondary Program."

In addition to the Definitions Section of this Certificate, the following definitions apply to this section:

ALLOWABLE EXPENSE.....means a Covered Service, when the Covered Service is covered at least in part by one or more Benefit Program covering the person for whom the claim is made.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition unless your stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the Benefit Program.

When a Benefit Program provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

BENEFIT PROGRAM.....means any of these which provides benefits or services for, or because of, medical or dental care or treatment:

- (i) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage.
- (ii) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX of the Social Security Act).

Each contract or other arrangement under (i) or (ii) above is a separate benefit program. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate program.

CLAIM DETERMINATION PERIOD.....means a calendar year. However, it does not include any part of a year during which a person has no coverage under

this Benefit Program, or any part of a year before the date this COB provision or a similar provision takes effect.

PRIMARY PROGRAM or SECONDARY PROGRAM.....means the order of payment responsibility as determined by the order of benefit determination rules.

When this Benefit Program is the Primary Program, its benefits are determined before those of the other Benefit Program and without considering the other program's benefits.

When this Benefit Program is a Secondary Program, its benefits are determined after those of the other Benefit Program and may be reduced because of the other program's benefits.

When there are more than two Benefit Programs covering the person, this Benefit Program may be a Primary Program as to one or more other programs, and may be a Secondary Program as to a different program or programs.

ORDER OF BENEFIT DETERMINATION

When there is a basis for a Claim under this Benefit Program and another Benefit Program, this Benefit Program is a Secondary Program which has its benefits determined after those of the other program, unless:

1. The other Benefit Program has rules coordinating its benefits with those of this Benefit Program; and
2. Both those rules and this Benefit Program's rules, described below, require that this Benefit Program's benefits be determined before those of the other Benefit Program.

This Benefit Program determines its order of benefit payments using the first of the following rules which applies:

1. Non-Dependent or Dependent

The benefits of the Benefit Program which covers the person as an employee, member or subscriber (that is, other than a dependent) are determined before those of the Benefit Program which covers the person as dependent; except that, if the person is also a Medicare beneficiary, Medicare is:

- a. Secondary to the Benefit Program covering the person as a dependent; and
- b. Primary to the Benefit Program covering the person as other than a dependent, for example a retired employee.

2. Dependent Child if Parents not Separated or Divorced

Except as stated in rule 3 below, when this Benefit Program and another Benefit Program cover the same child as a dependent of different persons, called "parents:"

- a. The benefits of the program of the parent whose birthday (month and day) falls earlier in a calendar year are determined before those of the program of the parent whose birthday falls later in that year; but
- b. If both parents have the same birthday, the benefits of the program which covered the parents longer are determined before those of the program which covered the other parent for a shorter period of time.

However, if the other Benefit Program does not have this birthday-type rule, but instead has a rule based upon gender of the parent, and if, as a result, the Benefit Programs do not agree on the order of benefits, the rule in the other Benefit Program will determine the order of benefits.

3. Dependent Child if Parents Separated or Divorced

If two or more Benefit Programs cover a person as a dependent child of divorced or separate parents, benefits for the child are determined in this order:

- a. First, the program of the parent with custody of the child;
- b. Then, the program of the spouse of the parent with the custody of the child; and
- c. Finally, the program of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the program of that parent has actual knowledge of those terms, the benefits of that program are determined first. The program of the other parent shall be the Secondary Program. This paragraph does not apply with respect to any Claim Determination Period or Benefit Program year during which any benefits are actually paid or provided before the entity has that actual knowledge. It is the obligation of the person claiming benefits to notify Blue Cross and Blue Shield and, upon its request, to provide a copy of the court decree.

4. Dependent Child if Parents Share Joint Custody

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Benefit Programs covering the child shall follow the order of benefit determination rules outlined in 2 above.

5. Active or Inactive Employee

The benefits of a Benefit Program which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Benefit Program which covered that person as a laid off or retired employee (or as that employee's dependent). If the other Benefit Program does not have this rule, and if, as a result, the Benefit Programs do not agree on the order of benefits, this rule is ignored.

6. Continuation Coverage

If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Benefit Program, the following shall be the order of benefit determination:

- a. First, the benefits of a Benefit Program covering the person as an employee, member or subscriber (or as that person's dependent);
- b. Second, the benefits under the continuation coverage.

If the other Benefit Program does not contain the order of benefits determination described within this rule, and if, as a result, the programs do not agree on the order of benefits, this requirement shall be ignored.

7. Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the Benefit Program which covered an employee, member or subscriber longer are determined before those of the Benefit Program which covered that person for the shorter term.

WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM

In the event this Benefit Program is a Secondary Program as to one or more other Benefit Programs, the benefits of this Benefit Program may be reduced.

The benefits of this Benefit Program will be reduced when the sum of:

1. The benefits that would be payable for the Allowable Expenses under this Benefit Program in the absence of this COB provision; and
2. The benefits that would be payable for the Allowable Expenses under the other Benefit Programs, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made;

Exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Benefit Program will be reduced so that they and the benefits payable under the other Benefit Programs do not total more than those Allowable Expenses.

If you are eligible for Medicare Part B, the benefits of this Benefit Program may be reduced taking into consideration the amount that would be payable for an Allowable Expense under Medicare Part B whether or not you have enrolled in Part B and/or received payment from Medicare.

When the benefits of this Benefit Program are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Benefit Program.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. Blue Cross and Blue Shield has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Blue Cross and Blue Shield need not tell, or get the consent of, any person to do this. Each person claiming benefits

under this Benefit Program must give Blue Cross and Blue Shield any facts it needs to pay the Claim.

FACILITY OF PAYMENT

A payment made under another Benefit Program may include an amount which should have been paid under this Benefit Program. If it does, Blue Cross and Blue Shield may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Benefit Program. Blue Cross and Blue Shield will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of payments made by Blue Cross and Blue Shield is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.

The “amount of payments made” includes the reasonable cash value of any benefits provided in the form of services.

**CONTINUATION OF COVERAGE
AFTER TERMINATION
(Illinois State Laws)**

This CONTINUATION OF COVERAGE AFTER TERMINATION section does not apply to Domestic Partners and their children.

The purpose of this section of your Certificate is to explain the options available for continuing your coverage after termination, as it relates to Illinois state legislation. The provisions which apply to you will depend upon your status at the time of termination. The provisions described in Article A will apply if you are the Eligible Person (see definitions) at the time of termination. The provisions described in Article B will apply if you are the spouse of or the party to a Civil Union with a retired Eligible Person and at least 55 years of age or former spouse of or the former party to a Civil Union with a retired Eligible Person who has died or from whom you have been divorced or no longer party to a Civil Union. The provisions described in Article C will apply if you are the dependent child of an Eligible Person who has died or if you have reached the limiting age under this Certificate and not eligible to continue coverage as provided under Article B.

Your continued coverage under this Certificate will be provided only as specified below. Therefore, after you have determined which Article applies to you, please read the provisions very carefully.

ARTICLE A: Continuation of coverage if you are the Eligible Person

If an Eligible Person's coverage under this Certificate should terminate because of termination of employment or membership or because of a reduction in hours below the minimum required for eligibility, an Eligible Person will be entitled to continue the Hospital, Surgical-Medical and/or Major Medical coverage provided under this Certificate for himself/herself and his/her eligible dependents (if he/she had Family Coverage on the date of termination). However, this continuation of coverage option is subject to the following conditions:

1. Continuation of coverage will be available to you only if you have been continuously insured under the Group Policy (or for similar benefits under any group policy which it replaced) for at least 3 months prior to your termination date or reduction in hours below the minimum required for eligibility.
2. Continuation of coverage will not be available to you if: (a) you are covered by Medicare, except if you have been covered under a group Medicare supplement policy, or (b) you have coverage under any other health care program which provides group hospital, surgical or medical coverage and under which you were not covered immediately prior to such termination or reduction in hours below the minimum required for eligibility, or (c) you decide to become a member of Blue Cross and Blue Shield on a "direct pay" basis.
3. If you decide to become a member of Blue Cross and Blue Shield on a "direct pay" basis, you may not, at a later date, elect the continuation of coverage option under this Certificate. Upon termination of the continuation of coverage period as explained in paragraph 6 below, the provisions of this

Certificate pertaining to "Extension of Benefits in Case of Termination" will apply and you may exercise the Conversion Privilege explained in the ELIGIBILITY SECTION of this Certificate.

4. Within 10 days of your termination of employment or membership or reduction in hours below the minimum required for eligibility, your Group will provide you with written notice of this option to continue your coverage. If you decide to continue your coverage, you must notify your Group, in writing, no later than 30 days after your coverage has terminated or reduction in hours below the minimum required for eligibility or 30 days after the date you received notice from your Group of this option to continue coverage. However, in no event will you be entitled to your continuation of coverage option more than 60 days after your termination or reduction in hours below the minimum required for eligibility.
5. If you decide to continue your coverage under this Certificate, you must pay your Group on a monthly basis, in advance, the total charge required by Blue Cross and Blue Shield for your continued coverage, including any portion of the charge previously paid by your Group. Payment of this charge must be made to Blue Cross and Blue Shield (by your Group) on a monthly basis, in advance, for the entire period of your continuation of coverage under this Certificate.
6. Continuation of coverage under this Certificate will end on the date you become eligible for Medicare, become a member of Blue Cross and Blue Shield on a "direct pay" basis or become covered under another health care program (which you did not have on the date of your termination or reduction in hours below the minimum required for eligibility) which provides group hospital, surgical or medical coverage. However, your continuation of coverage under this Certificate will also end on the first to occur of the following:
 - a. The date twelve months after the date the Eligible Person's coverage under this Certificate would have otherwise ended because of termination of employment or membership or reduction in hours below the minimum required for eligibility.
 - b. If you fail to make timely payment of required charges, coverage will terminate at the end of the period for which your charges were paid.
 - c. The date on which the Group Policy is terminated. However, if this Certificate is replaced by similar coverage under another group policy, the Eligible Person will have the right to become covered under the new coverage for the amount of time remaining in the continuation of coverage period. When your continuation of coverage period has expired, the provisions of this Certificate entitled EXTENSION OF BENEFITS IN CASE OF TERMINATION (when applicable) will apply to you.

ARTICLE B: Continuation of Coverage if you are the former spouse of an Eligible Person or spouse of a retired Eligible Person

If the coverage of the spouse of an Eligible Person should terminate because of the death of the Eligible Person, a divorce from the Eligible Person, dissolution of a Civil Union from the Eligible Person or the retirement of an Eligible Person, the former spouse or retired Eligible Person's spouse if at least 55 years of

age will be entitled to continue the coverage provided under this Certificate for himself/herself and his/her eligible dependents (if Family Coverage is in effect at the time of termination). However, this continuation of coverage option is subject to the following conditions:

1. Continuation will be available to you as the former spouse of an Eligible Person or spouse of a retired Eligible Person only if you provide the employer of the Eligible Person with written notice of the dissolution of marriage or Civil Union, the death or retirement of the Eligible Person within 30 days of such event.
2. Within 15 days of receipt of such notice, the employer of the Eligible Person will give written notice to Blue Cross and Blue Shield of the dissolution of your marriage or Civil Union to the Eligible Person, the death of the Eligible Person or the retirement of the Eligible Person as well as notice of your address. Such notice will include the Group number and the Eligible Person's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Eligible Person, Blue Cross and Blue Shield will advise you at your residence, by certified mail, return receipt requested, that your coverage and your covered dependents under this Certificate may be continued. Blue Cross and Blue Shield's notice to you will include the following:
 - a. a form for election to continue coverage under this Certificate.
 - b. notice of the amount of monthly charges to be paid by you for such continuation of coverage and the method and place of payment.
 - c. instructions for returning the election form within 30 days after the date it is received from Blue Cross and Blue Shield.
3. In the event you fail to provide written notice to Blue Cross and Blue Shield within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a former spouse or spouse of a retired Eligible Person under this Certificate as a result of the dissolution of marriage or Civil Union, the death or the retirement of the Eligible Person. Your right to continuation of coverage will then be forfeited.
4. If Blue Cross and Blue Shield fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of Blue Cross and Blue Shield's notice was to be sent are terminated as to all Eligible Persons under this Certificate.
5. If you have not reached age 55 at the time your continued coverage begins, the monthly charge will be computed as follows:
 - a. an amount, if any, that would be charged to you if you were an Eligible Person, with Individual or Family Coverage, as the case may be, plus
 - b. an amount, if any, that the employer would contribute toward the charge if you were the Eligible Person under this Certificate.

Failure to pay the initial monthly charge within 30 days after receipt of notice from Blue Cross and Blue Shield as required in this Article will terminate your continuation benefits and the right to continuation of coverage.

6. If you have reached age 55 at the time your continued coverage begins, the monthly charge will be computed for the first 2 years as described above. Beginning with the third year of continued coverage, an additional charge, not to exceed 20% of the total amounts specified in (5) above will be charged for the costs of administration.

7. Termination of Continuation of Coverage:

If you have not reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:

- a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).
 - b. on the date coverage would otherwise terminate under this Certificate if you were still married to or in a Civil Union with the Eligible Person; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the Eligible Person's death or entry of judgment dissolving the marriage or Civil Union existing between you and the Eligible Person, except in the event this entire Certificate is modified or terminated.
 - c. the date on which you remarry or enter into another Civil Union.
 - d. the date on which you become an insured employee under any other group health plan.
 - e. the expiration of 2 years from the date your continued coverage under this Certificate began.
8. If you have reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:
- a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).
 - b. on the date coverage would otherwise terminate, except due to the retirement of the Eligible Person, under this Certificate if you were still married to or in a Civil Union with the Eligible Person; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the Eligible Person's death, retirement or entry of judgment dissolving the marriage or Civil Union existing between you and the Eligible Person, except in the event this entire Certificate is modified or terminated.
 - c. the date on which you remarry or enter another Civil Union.
 - d. the date on which you become an insured employee under any other group health plan.
 - e. the date upon which you reach the qualifying age or otherwise establish eligibility under Medicare.
9. If you exercise the right to continuation of coverage under this Certificate you shall not be required to pay charges greater than those applicable to any other Eligible Person covered under this Certificate, except as specifically stated in these provisions.

10. Upon termination of your continuation of coverage, you may exercise the privilege to become a member of Blue Cross and Blue Shield on a "direct pay" basis as specified in the Conversion Privilege of the ELIGIBILITY SECTION of this Certificate.
11. If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in this Certificate.

ARTICLE C: Continuation of Coverage if you are the dependent child of an Eligible Person

If the coverage of a dependent child should terminate because of the death of the Eligible Person and the dependent child is not eligible to continue coverage under ARTICLE B or the dependent child has reached the limiting age under this Certificate, the dependent child will be entitled to continue the coverage provided under this Certificate for himself/herself. However, this continuation of coverage option is subject to the following conditions:

1. Continuation will be available to you as the dependent child of an Eligible Person only if you, or a responsible adult acting on your behalf as the dependent child, provide the employer of the Eligible Person with written notice of the death of the Eligible Person within 30 days of the date the coverage terminates.
2. If continuation of coverage is desired because you have reached the limiting age under this Certificate, you must provide the employer of the Eligible Person with written notice of the attainment of the limiting age within 30 days of the date the coverage terminates.
3. Within 15 days of receipt of such notice, the employer of the Eligible Person will give written notice to Blue Cross and Blue Shield of the death of the Eligible Person or of the dependent child reaching the limiting age, as well as notice of the dependent child's address. Such notice will include the Group number and the Eligible Person's identification number under this Certificate. Within 30 days of receipt of notice from the employer of the Eligible Person, Blue Cross and Blue Shield will advise you at your residence, by certified mail, return receipt requested, that your coverage under this Certificate may be continued. Blue Cross and Blue Shield's notice to you will include the following:
 - a. a form for election to continue coverage under this Certificate.
 - b. notice of the amount of monthly charges to be paid by you for such continuation of coverage and the method and place of payment.
 - c. instructions for returning the election form within 30 days after the date it is received from Blue Cross and Blue Shield.
4. In the event you, or the responsible adult acting on your behalf as the dependent child, fail to provide written notice to Blue Cross and Blue Shield within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a dependent child of an Eligible Person under this Certificate as a result of the death of the Eligible Person or the dependent child attaining the limiting age. Your right to continuation of coverage will then be forfeited.

5. If Blue Cross and Blue Shield fails to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of Blue Cross and Blue Shield's notice was to be sent are terminated as to all Eligible Persons under this Certificate.
6. The monthly charge will be computed as follows:
 - a. an amount, if any, that would be charged to you if you were an Eligible Person, plus
 - b. an amount, if any, that the employer would contribute toward the charge if you were the Eligible Person under this Certificate.

Failure to pay the initial monthly charge within 30 days after receipt of notice from Blue Cross and Blue Shield as required in this Article will terminate your continuation benefits and the right to continuation of coverage.

7. Continuation of Coverage shall end on the first to occur of the following:
 - a. if you fail to make any payment of charges when due (including any grace period specified in the Group Policy).
 - b. on the date coverage would otherwise terminate under this Certificate if you were still an eligible dependent child of the Eligible Person.
 - c. the date on which you become an insured employee, after the date of election, under any other group health plan.
 - d. the expiration of 2 years from the date your continued coverage under this Certificate began.
8. If you exercise the right to continuation of coverage under this Certificate, you shall not be required to pay charges greater than those applicable to any other Eligible Person covered under this Certificate, except as specifically stated in these provisions.
9. Upon termination of your continuation of coverage, you may exercise the privilege to become a member of Blue Cross and Blue Shield on a "direct pay" basis as specified in the Conversion Privilege of the ELIGIBILITY SECTION of this Certificate.
10. If this entire Certificate is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in this Certificate.

CONTINUATION OF COVERAGE FOR PARTIES TO A CIVIL UNION

The purpose of this section of your Certificate is to explain the options available for temporarily continuing your coverage after termination, if you are covered under this Certificate as the party to a Civil Union of an Eligible Person or as the dependent child of a party to a Civil Union. Your continued coverage under this Certificate will be provided only as specified below. Please read the provisions very carefully.

Continuation of Coverage

If you are a dependent who is a party to a Civil Union or their child and you lose coverage under this Certificate, the options available to a spouse or to a dependent child are described in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) section and the CONTINUATION COVERAGE RIGHTS UNDER COBRA section of this Certificate.

In addition to the events listed in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) provision if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Civil Union partnership with the Eligible Person terminates. Your Civil Union partnership will terminate if your partnership no longer meets the criteria described in the definition of "Civil Union" in the DEFINITIONS SECTION of this Certificate. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

Conversion Privilege

Upon termination of your continuation coverage, you may exercise the privilege to become a member of Blue Cross and Blue Shield on a "direct pay" basis as specified in the Conversion Privilege of the ELIGIBILITY SECTION of this Certificate.

CONTINUATION OF COVERAGE FOR DOMESTIC PARTNERS

The purpose of this section of your Certificate is to explain the options available for temporarily continuing your coverage after termination, if you are covered under this Certificate as the Domestic Partner of an Eligible Person or as the dependent child of a Domestic Partner. Your continued coverage under this Certificate will be provided only as specified below. Please read the provisions very carefully. Note: Domestic Partner coverage is available at your Employer's discretion. Contact your Employer for information on whether Domestic Partner coverage is available for your Group.

Continuation of Coverage

If you are the Domestic Partner or the dependent child of a Domestic Partner and you lose coverage under this Certificate, you have the same options as the spouse or dependent child of an Eligible Person to continue your coverage. The options available to a spouse or a dependent child are described in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) section and the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable to your Group.

NOTE: Certain employers may not be required to offer COBRA continuation coverage. See your Group Administrator if you have any questions about COBRA.

In addition to the events listed in the CONTINUATION OF COVERAGE AFTER TERMINATION (Illinois State Laws) section and the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Domestic Partnership with the Eligible Person terminates. Your Domestic Partnership will terminate if your partnership no longer meets the criteria described in the definition of "Domestic Partnership" in the DEFINITIONS SECTION of this Certificate. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This CONTINUATION COVERAGE RIGHTS UNDER COBRA section does not apply to your dependent who is your Domestic Partner and their children.

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE RIGHTS UNDER COBRA. See your employer or Group Administrator should you have any questions about COBRA.

Introduction

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;

- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for

procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period Of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension Of 18-Month Period Of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is prop-

erly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed Of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

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HOW TO FILE A CLAIM

In order to obtain your benefits under this Certificate, it is necessary for a Claim to be filed with Blue Cross and Blue Shield. To file a Claim, usually all you will have to do is show your Blue Cross and Blue Shield ID card to your Hospital or Physician (or other Provider) when you receive services. They will file your Claim for you. Remember however, it is your responsibility to insure that the necessary Claim information has been provided to Blue Cross and Blue Shield.

Once Blue Cross and Blue Shield receives your Claim, it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how much was paid. In some cases Blue Cross and Blue Shield will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on Blue Cross and Blue Shield's records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from your Group Administrator or from your local Blue Cross and Blue Shield office.
2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge.
3. Mail the completed Claim Form with attachments to:

Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, Illinois 60680-4112

In any case, Claims should be filed with Blue Cross and Blue Shield on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished the succeeding calendar year.) **Claims not filed within the required time period will not be eligible for payment.**

Should you have any questions about filing Claims, ask your Group Administrator or call your local Blue Cross and Blue Shield office.

FILING OUTPATIENT PRESCRIPTION DRUG CLAIMS

In certain situations, you will have to file your own Claims in order to obtain benefits for Outpatient prescription drugs. This is primarily true when you did not receive an identification card, the Pharmacy was unable to transmit a Claim or you received benefits from a non-Participating Prescription Drug Provider. To do so, follow these instructions:

1. Complete a prescription drug Claim Form. These forms are available from your Group Administrator or from your local Blue Cross and Blue Shield office.

2. Attach copies of all Pharmacy receipts to be considered for benefits. These receipts must be itemized.
3. Mail the completed Claim Form with attachments to:

Blue Cross and Blue Shield of Illinois
P.O. Box 14624
Lexington, KY 40512-4624

In any case, Claims must be filed no later than one year after the date a service is received. Claims not filed within one year from the date a service is received will not be eligible for payment.

INITIAL CLAIMS DETERMINATIONS

Blue Cross and Blue Shield will usually process all Claims according to the terms of the benefit program within 30 days of receipt of all information required to process a Claim. In the event that Blue Cross and Blue Shield does not process a Claim within this 30-day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the amount is \$1.00 or less. Blue Cross and Blue Shield will usually notify you, your valid assignee, or your authorized representative when all information required to process a Claim in accordance with the terms of the benefit program within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provisions in the GENERAL PROVISIONS section of this Certificate.)

If a Claim Is Denied or Not Paid in Full

If the claim for benefits is denied in whole or in part, you or your authorized representative shall be notified in writing of the following:

- a. The reasons for determination;
- b. A reference to the benefit plan provisions on which the denial is based, or the contractual, administrative or protocol for the determination;
- c. A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
- d. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- e. An explanation of Blue Cross and Blue Shield's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;

- f. In certain situations, a statement in non-English language(s) that written notices of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- g. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by Blue Cross and Blue Shield;
- h. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- i. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- j. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- k. In the case of a denial of an Urgent Care Clinical claim a description of the expedited review procedure applicable to such claims. An Urgent Care Clinical claim decision may be provided orally, so long as written notice is furnished to the claimant within three days of oral notification; and
- l. Contact information for applicable office of health insurance consumer assistance or ombudsman.

INQUIRIES AND COMPLAINTS

An **"Inquiry"** is a general request for information regarding, claims, benefits, or membership.

A **"Complaint"** is an expression of dissatisfaction by you either orally or in writing.

Blue Cross and Blue Shield has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to the following:

- Claims
- Quality of care

When your Complaint relates to dissatisfaction with a claim denial (or partial denial), then you have the right to a claim review/appeal as described in the CLAIM APPEAL PROCEDURES.

To pursue an Inquiry or Complaint, you may contact **Customer Service** at the number on the back of your ID card, or you may write to:

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, Illinois 60601

When you contact Customer Service to pursue an Inquiry or Complaint, you will receive a written response to your Inquiry or Complaint within 30 days of

receipt. Sometimes the acknowledgement and the response will be combined. If Blue Cross and Blue Shield needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information you will be contacted. If an inquiry or complaint is not resolved to your satisfaction, you may appeal to Blue Cross and Blue Shield.

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of claim. There are three types of claims as defined below.

1. **Urgent Care Clinical Claim** is any pre-service claim that requires Preauthorization, as described in this Benefit booklet, for benefit for medical care or Treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care of Treatment.
2. **Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
3. **Claim, also known as Post-Service Claim** is notification in a form acceptable to Blue Cross and Blue Shield that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information with Blue Cross and Blue Shield may request in connection with services rendered to you.

URGENT CARE CLINICAL CLAIMS*

Type of Notice or Extension	Timing
If your claim is incomplete, Blue Cross and Blue Shield must notify you within:	24 hours**
If you are notified that your claim is incomplete, you must then provide completed claim information to Blue Cross and Blue Shield within:	48 hours after receiving notice
Blue Cross and Blue Shield must notify you of the claim determination (whether adverse or not):	
If the initial claim is complete as soon as possible (taking into account medical exigencies), but no later than:	72 hours
After receiving the completed claim (if the initial claim is incomplete), within:	48 hours

* You do not need to submit Urgent Care Clinical Claims in writing. You should call Blue Cross and Blue Shield at the toll-Free number listed on the

back of your ID card as soon as possible to submit an Urgent Care Clinical Claim.

** Notification may be oral unless the claimant requests written notification.

PRE-SERVICE CLAIMS

Type of Notice or Extension	Timing
If your claim is filed improperly, Blue Cross and Blue Shield must notify you within:	5 days*
If your claim is incomplete, Blue Cross and Blue Shield must notify you within:	15 days
If you are notified that your claim is incomplete, you must then provide completed claim information to blue Cross and Blue Shield within:	45 days after receiving notice
Blue Cross and Blue Shield must notify you of the claim determination (whether adverse or not):	
If the initial claim is complete, within	15 days**
After receiving the completed claim (if the initial claim is incomplete), within:	30 days
If you require post-stabilization care after and Emergency within:	The time appropriate to the circumstance not to exceed one hour after the time of request

* Notification may be oral unless the claimant requests written notification.

** This period may be extended one time by Blue Cross and Blue Shield for up to 15 days, provided that Blue Cross and Blue Shield both (1) determines that such and extension is necessary due to matters beyond the control of the Plan and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which Blue Cross and Blue Shield expects to render a decision.

POST-SERVICE CLAIMS

Type of Notice or Extension	Timing
If your claim is incomplete, Blue Cross and Blue Shield must notify you within:	30 days
If you are notified that your claim is incomplete, you must then provide competed claim information to Blue Cross and Blue Shield within:	45 days after receiving notice
Blue Cross and Blue Shield must notify you of any adverse claim determination:	

If the initial claim is complete, within:	30 days*
After receiving the completed claim (if the initial claim is incomplete), within:	45 days

* This period may be extended one time by Blue Cross and Blue Shield for up to 15 days, provided that Blue Cross and Blue Shield both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which Blue Cross and Blue Shield expects to render a decision.

Concurrent Care

For benefit determination relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your claim for benefits.

CLAIM APPEAL PROCEDURES

Claim Appeal Procedures — Definitions

An “**Adverse Benefit Determination**” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, in response to a Claim, Pre-Service Claim or Urgent Care Clinical Claim, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by Blue Cross and Blue Shield and Blue Cross and Blue Shield reduces or terminates such treatment (other than by amendment or termination of the Group’s benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission is also an Adverse Benefit Determination.

In addition, an Adverse Benefit Determination, also includes an “Adverse Determination.”

An “**Adverse Determination**” means:

1. A determination by Blue Cross and Blue Shield or its designee utilization review organization that, based upon the information provided, a request for a benefit under Blue Cross and Blue Shield’s health benefit plan upon application of any utilization review technique does not meet Blue Cross and Blue Shield’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;
2. The denial, reduction or termination of or failure to provide or make payment, in whole or in part, for a benefit based on a determination by Blue Cross and Blue Shield or its designee utilization review organization that a preexisting condition was present before the effective date of coverage; or

3. A rescission of coverage determination, which does not include a cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

For purposes of this benefit program, we will refer to both an Adverse Determination and an Adverse Benefit Determination as an Adverse Benefit Determination, unless indicated otherwise.

Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An expedited clinical appeal is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, as well as a continued hospitalization. Before authorization of benefits for an ongoing course of treatment is terminated or reduced, Blue Cross and Blue Shield will provide you with notice and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, Blue Cross and Blue Shield will notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Blue Cross and Blue Shield will render a decision on the appeal within 24 hours after it receives the requested information, but in no event more than 48 hours after the appeal has been received by Blue Cross and Blue Shield.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for preauthorization, or any other determination made by Blue Cross and Blue Shield in accordance with the benefits and procedures detailed in your Health Benefit Plan.

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call Blue Cross and Blue Shield at the number on the back of your ID card.

If you believe Blue Cross and Blue Shield incorrectly denied all or part of your benefits, you may have your claim reviewed. Blue Cross and Blue Shield will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to Blue Cross and Blue Shield to request a claim review. Blue Cross and Blue Shield will need to know the reasons why you do not agree with the Adverse Benefit Determination. You may call 1-877-284-9302 or send your request to:

Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, IL 60690-1364

- In support of your claim review, you have the option of presenting evidence and testimony to Blue Cross and Blue Shield. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

Blue Cross and Blue Shield will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rational and information will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. If the initial benefit determination regarding the claim is based in whole or part on medical judgment, the appeal will be conducted by individuals associated with Blue Cross and Blue Shield and/or external advisors, but who were not involved in making the initial denial of your claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by Blue Cross and Blue Shield.

Upon receipt of a non-urgent concurrent, pre-service or post-service appeal Blue Cross and Blue Shield will notify the party filing the appeal within three business days of all the information needed to review the appeal.

Blue Cross and Blue Shield will render a decision of a non-urgent concurrent or pre-service appeal as s soon as practical, but in no event more than 30 days after the appeal has been received by Blue Cross and Blue Shield.

Blue Cross and Blue Shield will render a decision of the post-service appeal as soon as practical, but in no event more than 60 days after the appeal has been received by Blue Cross and Blue Shield.

Notice of Appeal Determination

Blue Cross and Blue Shield will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, orally of its determination followed-up by a written notice of the determination.

The written notice to you or your authorized representative will include:

- a. The reasons for the determination;

- b. A reference to the benefit plan provisions on which the determination is based, and the contractual, administrative or protocol for the determination;
- c. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- d. An explanation of Blue Cross and Blue Shield's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final decision on internal appeal;
- e. In certain situations, a statement in non-English language(s) that written notices of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- f. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by Blue Cross and Blue Shield;
- g. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- h. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- i. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request; and
- j. A description of the standard that was used in denying the claim and a discussion of the decision.
- k. Contact information for applicable office of health insurance consumer assistance or ombudsman.

If Blue Cross and Blue Shield's decision is to continue to deny or partially deny your claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the INDEPENDENT EXTERNAL REVIEW section below.

If an appeal is not resolved to your satisfaction, you may appeal Blue Cross and Blue Shield's decision to the Illinois Department of Insurance. The Illinois Department of Insurance will notify Blue Cross and Blue Shield of the appeal. Blue Cross and Blue Shield will have 21 days to respond to the Illinois Department of Insurance.

The operations of Blue Cross and Blue Shield are regulated by the Illinois Department of Insurance. Filing an appeal does not prevent you from filing a Complaint with the Illinois Department of Insurance or keep the Illinois Department of Insurance from investigating a Complaint.

The Illinois Department of Insurance can be contacted at:

Illinois Department of Insurance
Consumer Division
320 West Washington Street
Springfield, IL 62767
1-877-527-9431

You must exercise the right to internal appeal as a precondition to taking any action against Blue Cross and Blue Shield, either at law or in equity. If you have an adverse appeal determination, you may file civil action in a state or federal court.

If You Need Assistance

If you have any questions about the claims procedures or the review procedure, write or call Blue Cross and Blue Shield at 1-800-538-8833. Blue Cross and Blue Shield offices are open from 8:45 a.m. to 4:45 p.m., Monday through Friday.

Blue Cross and Blue Shield of Illinois
P.O. Box 2401
Chicago, IL 60690-1364

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at, 1-877-527-9431 or call the number on the back of your ID card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

INDEPENDENT EXTERNAL REVIEW

You or your authorized representative may make a request for a standard external review or expedited external review of an Adverse Determination or Final Adverse Determination by an independent review organization (IRO).

A **“Final Adverse Determination”** means an Adverse Determination involving a Covered Service that has been upheld by Blue Cross and Blue Shield or its designated utilization review organization, at the completion of Blue Cross and Blue Shield’s internal grievance process procedures.

1. Standard External Review

You or your authorized representative must submit a written request for a standard external independent review to the Director of the Illinois Department of Insurance (“Director”) within four months of receiving an Adverse Determination or Final Adverse Determination. You may submit additional information or documentation to support your request for the health care services. Within one business day after the date of receipt of the request, the Director will send a copy of the request to Blue Cross and Blue Shield.

- a. **Preliminary Review.** Within five business days of receipt of the request from the Director, Blue Cross and Blue Shield will complete a preliminary review of your request to determine whether:
- You were a covered person at the time health care service was requested or provided;
 - The service that is the subject of the Adverse Determination or the Final Adverse Determination is a Covered Service under this Certificate, but Blue Cross and Blue Shield has determined that the health care service is not covered;
 - You have exhausted Blue Cross and Blue Shield's internal appeal process, unless you are not required to exhaust Blue Cross and Blue Shield's internal appeal process pursuant to the Illinois Health Carrier External Review Act; and
 - You have provided all the information and forms required to process an external review.

For appeals relating to a determination based on treatment being experimental or investigational, Blue Cross and Blue Shield will complete a preliminary review to determine whether the requested service or treatment that is the subject of the Adverse Determination or Final Adverse Determination is a Covered Service, except for Blue Cross and Blue Shield's determination that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit. In addition, your health care provider has certified that one of the following situations is applicable:

- Standard health care services or treatments have not been effective in improving your condition;
- Standard health care services or treatments are not medically appropriate for you; or
- There is no available standard health care services or treatment covered by Blue Cross and Blue Shield that is more beneficial than the recommended or requested service or treatment.

In addition, a) your health care provider has certified in writing that the health care service or treatment is likely to be more beneficial to you, in the opinion of your health care provider, than any available standard health care services or treatments, or b) your health care provider who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to you than any available standard health care services or treatments.

- b. **Notification.** Within one business day after completion of the preliminary review, Blue Cross and Blue Shield shall notify the Director, you and your authorized representative, if applicable, in writing whether the re-

quest is complete and eligible for an external review. If the request is not complete or not eligible for an external review, the Director, you and your authorized representative shall be notified by Blue Cross and Blue Shield in writing of what materials are required to make the request complete or the reason for its ineligibility. Blue Cross and Blue Shield's determination that the external review request is ineligible for review may be appealed to the Director by filing a complaint with the Director. The Director may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the Director's decision shall be in accordance with the terms of your benefit program (unless such terms are inconsistent with applicable laws) and shall be subject to all applicable laws.

- c. **Assignment of IRO.** When the Director receives notice that your request is eligible for external review following the preliminary review, the Director will, within one business day after the receipt of the notice, a) assign an IRO on a random basis from those IROs approved by the Director; and (b) notify Blue Cross and Blue Shield, you and your authorized representative, if applicable, of the request's eligibility and acceptance for external review and the name of the IRO.

Within five business days after the date of receipt of the notice provided by the Director of assignment of an IRO, Blue Cross and Blue Shield shall provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, you or your authorized representative may, within five business days following the date of receipt of the notice of assignment of an IRO, submit in writing to the assigned IRO additional information that the IRO shall consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after five business days. If Blue Cross and Blue Shield or its designated utilization review organization does not provide the documents and information within five business days, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. A failure by Blue Cross and Blue Shield or designated utilization review organization to provide the documents and information to the IRO within five business days shall not delay the conduct of the external review. Within one business day after making the decision to end the external review, the IRO shall notify Blue Cross and Blue Shield, you and, if applicable, your authorized representative, of its decision to reverse the determination.

If you or your authorized representative submitted additional information to the IRO, the IRO shall forward the additional information to Blue Cross and Blue Shield within one business day of receipt from you or your authorized representative. Upon receipt of such information, Blue Cross and Blue Shield may reconsider the Adverse Determination or Final Adverse Determination. Such reconsideration shall not delay the external review. Blue Cross and Blue Shield may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. Within one business day after making the decision

to end the external review, Blue Cross and Blue Shield shall notify the the Director, IRO, you, and if applicable, your authorized representative of its decision to reverse the determination.

d. **IRO's Decision.** In addition, to the documents and information provided by Blue Cross and Blue Shield and you, or if applicable, your authorized representative, the IRO shall also consider the following information if available and appropriate:

- Your pertinent medical records;
- Your health care provider's recommendation;
- Consulting reports from appropriate health care providers and other documents submitted to Blue Cross and Blue Shield or its designee utilization review organization, you, your authorized representative or your treating provider;
- The terms of coverage under the benefit program;
- The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by Blue Cross and Blue Shield or its designated utilization review organization; and
- The opinion of the IRO's clinical reviewer or reviewers after consideration of the items described above.

Within one business day after the receipt of notice of assignment to conduct an external review with respect to a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the IRO will select one or more clinical reviewers, as it determines is appropriate, to conduct the external review, which clinical reviews must meet the minimum qualifications set forth in the Illinois Health Carrier External review Act, and neither you, your authorized representative, if applicable, nor Blue Cross and Blue Shield will choose or control the choice of the physicians or their health care professionals to be selected to conduct the external review. Each clinical reviewer will provide a written opinion to the IRO within 20 days after being selected by the IRO to conduct the external review on whether the recommended or requested health care services or treatment should be covered.

The IRO will make a decision within 20 days after the date it receives the opinion of each clinical review, which will be determined by the recommendation for majority of the clinical reviewers.

Within five days after the date of receipt of the necessary information, but in no event more than 45 days after the date of receipt of request for an external review, the IRO will render its decision to uphold or reverse the Adverse Determination or Final Adverse Determination and will no-

tify the Director, Blue Cross and Blue Shield, you and your authorized representative, if applicable of its decision.

With respect to experimental or investigational services or treatments, the IRO will make a decision within 20 days after the date it receives the option of each clinical reviewer, which will be determined by the recommendation of the majority of the clinical reviewers.

The written notice will include:

1. A general description of the reason for the request for external review;
2. The date the IRO received the assignment from the Director;
3. The time period during which the external review was conducted;
4. References to the evidence or documentation including the evidence-based standards, considered in reaching its decision or, in the case of external reviews of the experimental or investigational services or treatments, the written opinions of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;
5. The date of its decisions, and
6. The principal reason or reasons for its decision, including, what applicable, if any, evidence-based standards that were a basis for its decisions; and
7. The rationale for its decision.

Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, Blue Cross and Blue Shield shall immediately approve the coverage that was the subject of the determination. Benefits will not be provided for services or supplies not covered under the benefit program even if the IRO determines that the health care services being reviewed were medically appropriate.

The IRO is not bound by any claim determinations reached prior to the submission of information to the IRO. The Director, you and your authorized representative, if applicable, and Blue Cross and Blue Shield will receive written notice from the IRO. Until July 1, 2013, or such other date required by law, if you disagree with the determination of the IRO, you may appeal the decision of the IRO to the Illinois Department of Insurance.

2. Expedited External Review

If you have a medical condition where the timeframe for completion of (a) an expedited internal review of an appeal involving an Adverse Determination; (b) a Final Adverse Determination; or, (c) a standard external review as described above, would seriously jeopardize your life or health or your ability to regain maximum function, then you or your authorized representative may file a request for an expedited external review by an IRO not associated with Blue Cross and Blue Shield. In addition, if a Final Adverse Determination

concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility, then you or your authorized representative may request an expedited external review. You or your authorized representative may file the request immediately after a receipt of notice of Final Adverse Determination or if Blue Cross and Blue Shield fails to provide a decision on request for an expedited internal appeal within 48 hours.

You may also request an expedited external review if a Final Adverse Determination concerns a denial of coverage based on the determination that the treatment or service in question is considered experimental or investigational and your health care provider certifies in writing that the treatment or service would be significantly less effective if not started promptly.

Expedited external review will not be provided for retrospective adverse or final adverse determinations.

Your request for an expedited independent external review may be submitted to the Director either orally (by calling 1-877-850-4740) or in writing as set forth above for requests for standard external review.

Notification. Upon receipt of a request for an expedited external review, the Director shall immediately send a copy of the request to Blue Cross and Blue Shield. Blue Cross and Blue Shield shall immediately notify the Director, you and your authorized representative, if applicable, whether the expedited request is complete and eligible for an expedited external review. Blue Cross and Blue Shield's determination that the external review request is ineligible for review may be appealed to the Director by filing a complaint with the Director. The Director may determine that a request is eligible for expedited external review and require that it be referred for an expedited external review. In making such determination, the Director's decision shall be in accordance with the terms of the benefit program (unless such terms are inconsistent with applicable law) and shall be subject to all applicable laws.

Assignment of IRO. If your request is eligible for expedited external review, the Director shall immediately assign an IRO on a random basis from the list of IROs approved by the Director; and immediately notify Blue Cross and Blue Shield of the name of the IRO.

Upon receipt from the Director of the name of the IRO assigned to conduct the external review, Blue Cross and Blue Shield or its designated utilization review organization shall immediately (but in no case more than 24 hours after receiving such notice) provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, you or your authorized representative may submit additional information in writing to the assigned IRO. If Blue Cross and Blue Shield or its designated utilization review organization does not provide the documents and information within 24 hours, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. Within one business day after making the decision to end the external review, the IRO shall notify the Director, Blue Cross and Blue

Shield, you and, if applicable, your authorized representative, of its decision to reverse the determination.

As expeditiously as your medical condition or circumstances requires (but in no event more than 72 hours after the date of receipt of the request for an expedited external review) the assigned IRO will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and will notify the Director, Blue Cross and Blue Shield, you and, if applicable, your authorized representative. If the initial notice regarding its determination was not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation to the decision to you, the Director, Blue Cross and Blue Shield an, if applicable, your authorized representative, including all the information outlined under the standard process above.

If the external review was a review of experimental or investigational treatments, each clinical review shall provide an opinion orally or in writing to the assigned IRO as expeditiously as your medical condition or circumstances requires, but in no event less than five calendar days after being selected. Within 48 hours after the date it receives the opinion of each clinical reviewer, the IRO will make a decision and provide notice of the decision either orally or in writing g to the Director, the Claim Administrator, you and your authorized representative, if applicable.

If the IRO's initial notice regarding its determination was not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to you, the Director, the Claim Administrator and, if applicable, your authorized representative.

The assigned IRO is not bound by any decisions or conclusions reached during Blue Cross and Blue Shield's utilization review process or Blue Cross and Blue Shield's internal grievance process. Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, Blue Cross and Blue Shield shall immediately approve the coverage that was the subject of the determination. Benefits will not be provided for services or supplies not covered under the benefit program if the IRO determines that the health care services being appealed were medically appropriate. Until July 1, 2013, if you disagree with the determination of the IRO, you may appeal the decision of the IRO to the Illinois Department of Insurance.

An external review decision is binding on Blue Cross and Blue Shield. An external review decision is binding on you, except to the extent you have other remedies available under applicable federal or state law. You and your authorized representative may not file a subsequent request for external review involving the same Adverse Determination or Final Adverse Determination for which you have already received an external review decision.

GENERAL PROVISIONS

1. BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

Blue Cross and Blue Shield hereby informs you that it has contracts with certain Providers ("Plan Providers") in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which Blue Cross and Blue Shield is a party, including all persons covered under this Certificate. Under certain circumstances described in its contracts with Plan Providers, Blue Cross and Blue Shield may:

- receive substantial payments from Plan Providers with respect to services rendered to you for which Blue Cross and Blue Shield was obligated to pay the Plan Provider, or
- pay Plan Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Plan Providers other substantial allowances under Blue Cross and Blue Shield's contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by Blue Cross and Blue Shield under this Certificate and the calculation of all required deductible and Coinsurance amounts payable by you under this Certificate shall be based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Your Group has been advised that Blue Cross and Blue Shield may receive such payments, discounts and/or other allowances during the term of the Policy. Neither the Group nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how Blue Cross and Blue Shield's separate financial arrangements with Providers work, please consider the following example:

- a. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is \$1,000. How is the \$1,000 bill paid?
- b. You personally will have to pay the deductible and Coinsurance amounts set out in your Certificate.
- c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital's Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the \$1,000 Hospital bill would be reduced by 30% to \$700 for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

- d. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the \$1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of \$700, or \$140. You should note that your 20% Coinsurance is based on the full \$1,000 Hospital bill, after it is reduced by the applicable ADP.
- e. After taking into account the deductible and Coinsurance amounts, Blue Cross and Blue Shield will satisfy its portion of the Hospital bill. In most cases, Blue Cross and Blue Shield has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money Blue Cross and Blue Shield would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is \$1,000, your deductible has already been satisfied, and your Coinsurance is \$140, then Blue Cross and Blue Shield has to satisfy the rest of the Hospital bill, or \$860. Assuming Blue Cross and Blue Shield has a contract with the Hospital, Blue Cross and Blue Shield will usually be able to satisfy the \$860 bill that remains after your Coinsurance and deductible, by paying less than \$860 to the Hospital, often substantially less than \$860. Blue Cross and Blue Shield receives, and keeps for its own account, the difference between the \$860 bill and whatever Blue Cross and Blue Shield ultimately pays under its contracts with Plan Providers, and neither you nor your Group are entitled to any part of these savings.

Other Blue Cross and Blue Shields' Separate Financial Arrangements with Providers

Out-of-Area Services

Blue Cross and Blue Shield of Illinois, a division of Health Care Service Corporation, herein called "the Plan" has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of the Plan's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program and may include negotiated National Account arrangements available between the Plan and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside our service area, you will obtain care from healthcare Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from Non-Participating Providers. Our payment practices in both instances are described below.

BlueCard®Program

Under the BlueCard®Program, when you access Covered Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for

contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever you access Covered Services outside the Plan's service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to the Plan.

To help you understand how this calculation would work, please consider the following example:

- a. Suppose you receive covered medical services for an illness while you are on vacation outside of Illinois. You show your identification card to the Provider to let him or her know that you are covered by the Plan.
- b. The provider has negotiated with the Host Blue a price of \$80, even though the Provider's standard charge for this service is \$100. In this example, the Provider bills the Host Blue \$100.
- c. The Host Blue, in turn, forwards the claim to the Plan and indicates that the negotiated price for the covered service is \$80. The Plan would then base the amount you must pay for the service — the amount applied to your deductible, if any, and your coinsurance percentage — on the \$80 negotiated price, not the \$100 billed charge.
- d. So, for example, if your coinsurance is 20%, you would pay \$16 (20% of \$80), not \$20 (20% of \$100). You are not responsible for amounts over the negotiated price for a covered service.

PLEASE NOTE: The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this Certificate.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

In some instances federal law or the laws of a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, your claims for Covered Services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount you pay for Covered Services under this arrangement will be calculated based on lower of either billed covered charges or negotiated price (Refer to the description of negotiated price under Section A., BlueCard Program) made available to the Plan by the Host Blue.

Non-Participating Healthcare Providers Outside the Plan's Service Area

Liability Calculation

a. In General

When Covered Services are provided outside of the Plan's service area by Non-Participating Providers, the amount(s) you pay for such services will be calculated using the methodology described in the Certificate for Non-Participating Providers located inside our service area. You may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph.

b. Exceptions

In some exception cases, the Plan may, but is not required to, in its sole and absolute discretion, negotiate a payment with such Non-Participating Provider on an exception basis.

Blue Cross and Blue Shield's Separate Financial Arrangements with Prescription Drug Providers

Blue Cross and Blue Shield hereby informs you that it has contracts, either directly or indirectly, with prescription drug providers ("Participating Prescription Drug Providers") to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which Blue Cross and Blue Shield is a party, including all persons covered under this Certificate. Under its contracts with Participating Prescription Drug Providers, Blue Cross and Blue Shield may receive from these providers discounts for prescription drugs dispensed to you. Actual discounts used to calculate your share of the cost of Prescription Drugs will vary. Some discounts are currently based on Average Wholesale Price ("AWP") which is determined by a third party and is subject to change.

You understand that Blue Cross and Blue Shield may receive such discounts. Neither the Group nor you are entitled to receive any portion of any dis-

counts. The drug fees/discounts that Blue Cross and Blue Shield has negotiated with Prime Therapeutics LLC (“Prime”) through the Pharmacy Benefit Management (“PBM”) Agreement, will be used to calculate your share of the cost of Prescription Drugs for both retail and home delivery/specialty drugs. Except for home delivery/specialty drugs, the PBM Agreement requires that the fees/discounts that Prime has negotiated with pharmacies (or other suppliers) are passed-through to the Plan (and ultimately to you as described above).

Coinsurance amounts payable by you under this Certificate will be calculated on the basis of the provider’s eligible charge or the agreed upon cost between the Participating Prescription Drug Provider and Blue Cross and Blue Shield for a prescription drug, whichever is lower.

To help you understand how Blue Cross and Blue Shield’s separate financial arrangements with Participating Prescription Drug Providers work, please consider the following example:

- a. Assume you have a prescription dispensed and the normal, full amount of the prescription drug is \$100. How is the \$100 bill paid?
- b. You personally will have to pay the Coinsurance amount set out in this Certificate.
- c. However, for purposes of calculating your Coinsurance amount, the full amount of the prescription drug would be reduced by the discount. In our example, if the applicable discount were 20%, the \$100 prescription drug bill would be reduced by 20% to \$80 for purposes of calculating your Coinsurance amount.
- d. In our example, if your Coinsurance obligation is 25%, you personally will have to pay 25% of \$80, or \$20. You should note that your 25% Coinsurance is based upon the discounted amount of the prescription and not the full \$100 bill.

For the home delivery pharmacy and specialty pharmacy program owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the home delivery pharmacy and/or specialty pharmacy program. The Plan pays a fee to Prime for pharmacy benefit services. A portion of Prime’s PBM fees are tied to certain performance standards, including, but not limited to, claims processing, customer service response, and home deliver processing.

“Weighted Paid Claim” refers to the methodology of counting claims for purposes of determining Blue Cross and Blue Shield’s fee payment to Prime. Each retail (including claims dispensed through PBM’s specialty pharmacy program) paid claim equals one Weighted Paid Claim; each extended supply or home deliver order paid claim equals three Weighted Paid Claims. However, Blue Cross and Blue Shield pays Prime a Program Management Fee (“PMF”) on a per paid claim basis. “Funding Levers” means a mechanism through which the Plan funds the fees (net fee, ancillary fees and special project fees) owed to PBM. Funding Levers always include manufacturer ad-

ministrative fees, home delivery utilization, participating pharmacy transaction fees, and, if elected by the Plan, may include rebates and retail spread. The Plan's net fee owed to Prime for core services will be offset by the Funding Levers. The Plan pays Prime the net fee for core services, ancillary fees and special project fees, offset by all applicable Funding Levers as agreed upon under the terms of its agreement with Prime. The net fee is calculated based on a fixed dollar amount per Weighted Paid Claim.

The amounts received by Prime from the Plan, pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to the Plan (as described above), administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to you as expenses, or accrue to the benefit of you, unless otherwise specifically set forth in this Certificate. Additional information about these types of fees or the amount of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 3% of the total sales for all rebatable products of such manufacturer dispensed during any given calendar year to members of the Plan and other Blue Plan operating divisions.

Blue Cross and Blue Shield's Separate Financial Arrangements with Pharmacy Benefit Managers

Blue Cross and Blue Shield owns a significant portion of the equity of Prime Therapeutics LLC and informs you that Blue Cross and Blue Shield has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on Blue Cross and Blue Shield's behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products.

Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of the Plan, but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufacturers to cover the administrative costs of processing late payments). The Plan may receive such rebates from Prime. You are not entitled to receive any portion of any such rebates as they are calculated into the pricing of the product.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

- a. Under this Certificate, Blue Cross and Blue Shield has the right to make any benefit payment either directly to the Provider of the Covered Services or to you, unless reasonable evidence of a properly executed and enforceable Assignment of Benefit Payment has been received by the Plan sufficiently in advance of the Plan's benefit payment. The Plan reserves the right to require submission of a copy of the Assignment of Benefit Payment. For example, Blue Cross and Blue Shield may pay be-

nefits to you if you receive Covered Services from a Non-Plan Provider. Blue Cross and Blue Shield is specifically authorized by you to determine to whom any benefit payment should be made.

- b. Once Covered Services are rendered by a Provider, you have no right to request Blue Cross and Blue Shield not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, Blue Cross and Blue Shield will have no liability to you or any other person because of its rejection of such request.
- c. Except for the Assignment of Benefit Payment described above, either this Certificate or a Covered Person's claim for benefits under this Certificate is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person, and Coverage under this Certificate is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

3. YOUR PROVIDER RELATIONSHIPS

- a. The choice of a Provider is solely your choice and Blue Cross and Blue Shield will not interfere with your relationship with any Provider.
- b. Blue Cross and Blue Shield does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. Blue Cross and Blue Shield is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by Blue Cross and Blue Shield. Any contractual relationship between a Physician and a Plan Hospital or other Plan Provider shall not be construed to mean that Blue Cross and Blue Shield is providing professional service.
- c. The use of an adjective such as Plan or Participating in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Plan, Participating or any similar modifier or the use of a term such as Non-Plan or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.
- d. Each Provider provides Covered Services only to you and does not deal with or provide any services to your Group (other than as an individual Covered Person) or your Group's ERISA Health Benefit Program.

4. AGENCY RELATIONSHIPS

The Group is your agent under this Certificate. The Group is not the agent of Blue Cross and Blue Shield.

All information you and the Group provide to Blue Cross and Blue Shield will be relied upon as accurate and complete. The Group must promptly notify Blue Cross and Blue Shield of any changes to such information.

5. NOTICES

Any information or notice which you furnish to Blue Cross and Blue Shield under this Certificate must be in writing and sent to Blue Cross and Blue Shield at its offices at 300 East Randolph, Chicago, Illinois 60601-5099 (unless another address has been stated in this Certificate for a specific situation). Any information or notice which Blue Cross and Blue Shield furnishes to you must be in writing and sent to you at your address as it appears on Blue Cross and Blue Shield's records or in care of your Group and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on Blue Cross and Blue Shield's records.

6. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under this Certificate, prior to the expiration of sixty (60) days after a Claim has been furnished to Blue Cross and Blue Shield in accordance with the requirements of this Certificate. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to Blue Cross and Blue Shield in accordance with the requirements of this Certificate.

7. INFORMATION AND RECORDS

You agree that it is your responsibility to ensure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under this Certificate, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to Blue Cross and Blue Shield or its agent, and agree that any such Provider, person or other entity may furnish to Blue Cross and Blue Shield or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, Blue Cross and Blue Shield may furnish similar information and records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish Blue Cross and Blue Shield and/or your employer or group administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any change in Medicare eligibility status in order that Blue Cross and Blue Shield be able to make Claim Payments in accordance with MSP laws.

8. VALUE BASED DESIGN PROGRAMS

Blue Cross and Blue Shield and your employer has the right to offer health behavior wellness, maintenance, or improvement programs that allow for a

reward, a contribution, a penalty, a differential in premiums or in medical, prescription drug or equipment Copayments, Coinsurance, deductibles, or costs, or a combination of these incentives or disincentives for participation in any such program offered or administered by Blue Cross and Blue Shield, or an entity chosen by Blue Cross and Blue Shield to administer such programs. In addition, discount programs for various health and wellness-related or insurance-related items and services may be available from time-to-time. Such programs may be discontinued with or without notice.

Contact Blue Cross and Blue Shield for additional information regarding any value based programs offered by Blue Cross and Blue Shield.

Contact your employer for additional information regarding any value based programs offered by your employer.

9. CONFORMITY WITH STATE STATUTES

This Certificate provides, at a minimum, coverage as required by Illinois law. Laws in some other states require that certain benefits or provisions be provided to you if you are a resident of their state when the policy that insures you is not issued in your state. In the event any provision of this Certificate, on its effective date, conflicts with the laws of the state in which you permanently reside, you will be provided the greater of the benefit under this Certificate or that required under the laws of the state in which you permanently reside.

10. MEMBER DATA SHARING

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Blue Cross and Blue Shield of Illinois, a division of Health Care Services Corporation, or, if you do not reside in the Blue Cross and Blue Shield of Illinois service area, by the Host Blues whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise from involuntary termination of your health coverage sponsored by the Group/Employer but solely as a result of a reduction in force, plant/office closing(s) or group health plan termination (in whole or in part). As part of the overall plan of benefits that Blue Cross and Blue Shield of Illinois offers to, you, if you do not reside in the Blue Cross and Blue Shield of Illinois service area, Blue Cross and Blue Shield of Illinois may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which you reside. To do this we may (1) communicate directly with you and/or (2) provide the Host Blues whose service area covers the geographic area in which you reside, with your personal information and may also provide other general information relating to your coverage under the Policy the Group/Employer has with Blue Cross and Blue Shield of Illinois to the extent reasonably necessary to enable the relevant Host Blues to offer you coverage continuity through replacement coverage.

11. RELIGIOUS EMPLOYER EXEMPTION AND ELIGIBLE ORGANIZATION ACCOMMODATION

A certification(s) may have been provided to BCBSIL that your group health plan is established or maintained by an organization(s) that is a “religious employer(s)” as defined in 45 C.F.R. 147.131(a), as modified or replaced, and qualifies for a religious employer exemption from the Affordable Care Act requirement to cover certain contraceptive services without cost sharing under guidelines supported by the Health Resources and Services Administration (“Religious Employer Exemption”). Provided that the Religious Employer Exemption is satisfied for your group health plan, then coverage under your group health plan will not include coverage for some or all of such contraceptives services. Please call Customer Service at the number on the back of your ID card for more information. Questions regarding the Religious Employer Exemption should be directed to your Group.

In addition, a certification(s) may have been provided to BCBSIL that your group health plan is established or maintained by an organization(s) that is an “eligible organization(s)” as defined in 45 C.F.R. 147.131(b), as modified or replaced, and qualifies for an eligible organization accommodation with respect to the Affordable Care Act requirement to cover certain contraceptive services without cost sharing under guidelines supported by the Health Resources and Services Administration (“Eligible Organization Accommodation”). Provided that the Eligible Organization Accommodation is satisfied, coverage under your group health plan will not include coverage for some or all of such contraceptives services. Please call Customer Service at the number on the back of your ID card for more information. If you have questions regarding the certification(s), you may contact your Group. For other questions about the Eligible Organization Accommodation, you may contact Customer Service at the number on the back of your ID card.

12. ENTIRE CONTRACT

The entire contract consists of Group Policy, including the agreement between Blue Cross and Blue Shield and the Group, any addenda, this Certificate, the Group’s application and the Plan, as appropriate, along with any exhibits, appendices, addenda and/or other required information and the individual application(s) of the persons covered under the Policy, benefit and premium notification documents, if any, and rate summary documents, if any. All statements contained in the application will be deemed representations and not warranties. No such statements will be used to void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application.

No agent has the authority to modify or waive any part of the Group Policy, to extend the time for payment of premiums, or to waive any of the rights or requirements of Blue Cross and Blue Shield. No modifications of the Group Policy will be valid unless evidenced by an endorsement or amendment of the Group Policy, signed by an executive officer of Blue Cross and Blue Shield and delivered to the Group, and unless such approval be endorsed hereon or attached hereto.

REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for Covered Services described in this Certificate, you agree:

- a. Blue Cross and Blue Shield has the right to reimbursement for all benefits Blue Cross and Blue Shield provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of that sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which Blue Cross and Blue Shield has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.
- b. Blue Cross and Blue Shield is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits Blue Cross and Blue Shield provided for that sickness or injury.

Blue Cross and Blue Shield shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses for which Blue Cross and Blue Shield has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that Blue Cross and Blue Shield may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.™

Plan Name: GPS027PPOSILO

Account No: P244680012.0114

www.bcbsil.com

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

IL-G-P-OF-FR

EXHIBIT I

DISCOVER FINANCIAL SERVICES

WELFARE BENEFITS PLAN

As Amended and Restated Effective as of January 1, 2014

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**DISCOVER FINANCIAL SERVICES
WELFARE BENEFITS PLAN**

ARTICLE I

GENERAL PROVISIONS

1.1 Effective Date. The Company, which established the Plan in connection with its spin-off from Morgan Stanley effective July 1, 2007 and maintains the Plan, hereby amends and restates the Plan effective as of the Effective Date.

1.2 Purpose. The purposes of the Plan are (a) to offer Eligible Employees an opportunity to obtain certain medical, dental, vision, flexible spending account, life and accident, disability, long-term care, legal assistance, employee assistance, severance pay and commuter benefits; and (b) to provide Eligible Employees an opportunity to pay for certain benefits on a pre-tax basis. Benefits are provided under the Plan through a number of Participating Programs. The Plan is intended to constitute a welfare benefit plan under Section 3(1) of ERISA, and the Plan is to be administered and interpreted in a manner consistent with ERISA, the applicable provisions of the Code, and the regulations promulgated thereunder. Nothing in this Plan document, however, will subject any Participating Program to ERISA if the Participating Program would not otherwise be covered by ERISA.

1.3 Participating Programs. The Plan consolidates and incorporates herein a broad range of welfare plan benefit programs maintained by the Company, some of which are provided through insurance policies with an independent insurance company, and a cafeteria program within the meaning of Section 125 of the Code. The Plan includes the following health and welfare benefit programs: health (i.e., medical, dental, vision) benefits intended to comply with Section 105 of the Code, a flexible benefits arrangement intended to comply with Section 125 of the Code, a dependent care assistance program intended to comply with Section 129 of the Code, life insurance benefits, disability benefits, accidental death and dismemberment benefits, business travel accident insurance benefits, long-term care insurance, legal assistance benefits, employee assistance program, severance pay benefits, and commuter benefits (the "Participating Programs").

(a) The Participating Programs include those that are identified in Supplement A, as well as any welfare benefit programs maintained by the Company that may be added from time to time. The Program Documents listed in Supplement A that describe the specific benefits provided by each Participating Program, the individuals covered by each Participating Program, and the other terms and conditions of each Participating Program, as amended from time to time, are a part of this Plan and are incorporated herein by this reference.

(b) The Plan sets forth uniform rules and policies for all Participating Programs. The Participating Programs are intended to conform to the written Plan document as well as to comply with applicable laws. If a Participating Program is insured and there is a conflict between the specific terms of a Program Document and the

terms of the Plan, the Program Document will control. For all other Participating Programs, if there is a conflict between the specific terms of a Program Document and the terms of the Plan, the Plan will control (unless contrary to applicable law), except for terms exclusively applicable to a Participating Program, which are set forth in the applicable Program Document.

(c) For purposes of satisfying applicable nondiscrimination rules under Section 105 of the Code, each Participating Program may be tested separately.

(d) All Participating Programs offered under the Plan will constitute a single plan for purposes of the annual reporting requirements of the Code and ERISA. Notwithstanding the foregoing, any separate Participating Program required to receive an opinion from an independent qualified public accountant pursuant to Section 103(a)(3) of ERISA will be deemed a separate welfare benefit plan for purposes of the annual reporting requirements of the Code and ERISA.

1.4 Applicability of the Plan. The Plan shall apply only to eligible individuals who are Employees of a Participating Employer on or after January 1, 2014, except to the extent a Participating Program expressly covers an individual as a former Employee or as a Dependent of a former Employee, such as in the case of COBRA continuation coverage. The rights and benefits of Eligible Employees whose employment terminated prior to the Effective Date shall be determined in accordance with the Program Documents as in effect on the last day such Employees were employed by a Participating Employer, subject to any conditions or restrictions set forth in the applicable Program Documents and provided that employees who elect COBRA coverage following a termination of employment may have benefit terms modified or amended to the same extent that similarly situated active employees may have benefit terms modified or amended under the Plan or any Participating Program.

1.5 Gender and Number. Unless the context clearly indicates otherwise, words in any gender shall include any other gender, the plural shall include the singular, and the singular shall include the plural.

1.6 Headings. All heading and captions used in the Plan are used as a matter of convenience and for reference only, and in no way shall they be considered in determining the scope or intent of the Plan or in interpreting or construing any Plan provisions.

ARTICLE II

DEFINITIONS

2.1 Incorporation of Definitions Generally. Participating Programs are documented through the Program Documents listed in Supplement A. Such Program Documents listed in Supplement A are incorporated by reference into and form a part of this Plan document. This Section 2.1 further incorporates by reference the terms and definitions that are specific to each Participating Program. Definitions under this Article II will apply uniformly and without exception to all Participating Programs and Supplements, unless otherwise specified in the applicable Program Document or an applicable Supplement.

2.2 Accident Participating Program. “Accident Participating Program” means the accidental death and dismemberment insurance benefit program(s) (as set forth in the Program Documents listed in Supplement A, as amended from time to time) that is incorporated herein and forms a part of this Plan.

2.3 Account. “Account” means a bookkeeping record maintained with respect to each Participant that reflects from time to time the amounts attributable to Compensation Reduction Amounts made on the Participant’s behalf and the manner in which the Participant has allocated those contributions among the Flexible Benefit Options offered under the Plan, subject to forfeitures affecting the Participant under the Plan. Separate Accounts shall be maintained for each Participant for each Flexible Benefit Option selected by the Participant.

2.4 Adverse Benefit Determination. “Adverse Benefit Determination” means a denial, reduction, or termination of a benefit, or a failure to provide or make a benefit payment (in whole or in part), including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Participant’s eligibility to participate in a Plan. For Participating Programs that are group health plans, this shall also include a denial, reduction, termination, or failure to provide or make a payment (in whole or in part) that is based on the application of any utilization review or a determination that a benefit is experimental, investigational, or not medically necessary or appropriate. For Participating Programs that are subject to the “market reform” provisions of PPACA, an “Adverse Benefit Determination” shall also include any rescission of coverage (as described in 29 CFR 2590.715-2712) whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

2.5 BTA Participating Program. “BTA Participating Program” means the business travel accident insurance benefit program (as set forth in the Program Documents listed in Supplement A, as amended from time to time) that is incorporated herein and forms a part of this Plan.

2.6 Change in Status. “Change in Status” means one of the following events, as well as any other event defined as a change in status under Section 125 of the Code and the regulations issued thereunder that the Plan Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis:

- (a) an event that changes the legal marital status of an Eligible Employee (including marriage, death of the Eligible Employee’s Spouse or Domestic Partner, divorce, legal separation or annulment, and events that result in an Eligible Employee gaining or losing a Domestic Partner);

- (b) an event that changes the number of Children of an Eligible Employee, including the birth, adoption, placement for adoption, or death of a Child;

- (c) an event that changes the employment status of an Eligible Employee or his Dependent (including, but not limited to, termination or commencement of employment, commencement of or return from an unpaid leave of absence, a change in worksite, or a change in employment status that causes the individual to become or cease to be eligible under a Participating Program, such as switch from part-time to full-time

status or vice versa or transferring to or returning from an international assignment (except as otherwise provided in the applicable Program Documents);

(d) an event that causes a Child Dependent to either satisfy or cease to satisfy the eligibility requirements under the Plan or any Participating Program, due to the attainment of age, student status or any other similar circumstances as provided in the Plan or any Participating Program; or

(e) a change in the place of residence of an Employee, his Spouse or Domestic Partner, or Child Dependent.

2.7 Child. A “Child” means a biological child, a legally adopted child (or child placed for adoption), a stepchild, a foster child, a child for whom the Eligible Employee, Spouse or Domestic Partner is a legal guardian, or a child for whom the Eligible Employee has legal custody.

2.8 Claimant. “Claimant” means any person who believes he or she is entitled to receive a benefit under the Plan and files a claim in accordance with Article XI.

2.9 Claims Administrator. “Claims Administrator” means, with respect to any Participating Program, the person(s) or entity(ies) appointed by the Plan Administrator to decide, in its sole discretion, claims for benefits, or the person(s) or entity(ies) appointed by the Plan Administrator to decide, in its sole direction, appeals of denied claims for benefits (also referred to herein as the “Appeals Administrator”). The Claims Administrator will be a fiduciary (with respect to the authority delegated to the Claims Administrator) of the Plan.

(a) Fully Insured Participating Programs. The Claims Administrator for the insured Participating Programs will be the insurance company issuing the insurance policy or contract. Each Claims Administrator under an insured Participating Program will have full discretionary authority to determine claims and appeals under such Participating Program, subject to the terms of the insurance policy contract under which benefits are provided.

(b) Self-Funded Participating Programs. The Claims Administrator for the self-insured Participating Programs will be the Plan Administrator or its delegate. To the extent such authority is delegated by the Plan Administrator, the Claims Administrator for a self-funded Participating Program will have the full discretionary authority to determine claims and appeals under such Participating Program.

(c) Eligibility Determinations. The Plan Administrator shall have the full discretionary authority to determine eligibility under a Participating Program, except to the extent such authority has been delegated to the Claims Administrator for the Participating Program. The Plan Administrator’s eligibility determinations under a Participating Program are made by the Company’s Claims Committee and the Company’s Hearing Panel reviews any appeals of the eligibility determinations made by the Claims Committee.

2.10 Claims Committee. “Claims Committee” means the Discover Claims Committee, or such other individual or committee designated by the Plan Administrator to make eligibility determinations under a particular Participating Program.

2.11 Code. “Code” means the Internal Revenue Code of 1986, as amended from time to time, and the regulations thereunder. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation that amends, supplements or replaces such section or subsection.

2.12 Company. “Company” means Discover Financial Services.

2.13 Compensation. Except with respect to the Severance Participating Program (for which the definition of “Compensation” or “pay” shall be determined as set forth in the applicable Program Document(s)), “Compensation” means the Employee’s “health and welfare eligible earnings” or “HWEE.” An Employee’s HWEE is the greater of (a) his annualized base salary in effect at the time HWEE is calculated with respect to a particular Participating Program, or (b) his most recent twelve (12) months of “eligible pay,” as calculated annually. “Eligible pay” for purposes of determining an Employee’s HWEE means an Employee’s actual earnings, including pre-tax contributions to the Company’s 401(k) plan and flex and commuter assistance plans, and paid equity awards, less referral fees, expense allowances and imputed income. HWEE is calculated according to the following:

(a) In General. Except as specifically set forth in subsections (b), (c) or (d) below, an Employee’s HWEE is calculated of the Employee’s hire date with respect to his initial enrollment under Section 5.1(a), and prior to his annual enrollment under Section 5.1(b) for each subsequent Plan Year.

(b) Re-Employment. For an Employee who is rehired more than one year following his termination of employment with the Participating Employers, his HWEE is his annualized base salary as of his date of hire. If an Employee is rehired within 31 days following his termination of employment with the Participating Employers, his HWEE is his HWEE as in effect as of his date of termination of employment. If an Employee is rehired more than 31 days but less than one year following his termination of employment with the Participating Employers, his HWEE is the greater of (i) his annualized base salary as of his rehire date, or (ii) his HWEE in effect as of his date of termination of employment.

(c) Transfers. If a newly Eligible Employee who was not previously an Eligible Employee due to his international non-U.S. benefits-eligible position transfers employment and becomes an Eligible Employee, his HWEE is his prior calendar year eligible pay.

(d) LTD and BTA Participating Programs. For the LTD Participating Program and the BTA Participating Program, an Employee’s HWEE is calculated in the first quarter of the calendar year using the greater of (i) updated base salary and scheduled hours (if less than full-time), or (ii) prior actual calendar year eligible pay. This recalculated HWEE is then used to determine the Employee’s benefit under the LTD

Participating Program and contribution amounts for the LTD and BTA Participating Programs for the year retroactive to January 1 of the Plan Year.

2.14 Compensation Reduction Amount. “Compensation Reduction Amount” means the portion of a Participant’s cash Compensation that is contributed through a salary reduction election in accordance with Section 5.2 and in an amount sufficient to fund benefits that the Participant is to receive under the Plan.

2.15 Creditable Coverage.

(a) Creditable Coverage includes coverage of an individual under: (i) a group health plan; (ii) health insurance coverage; (iii) Medicare; (iv) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928 (Medicaid); (v) Chapter 55 of Title 10, United States Code (uniformed services healthcare); (vi) a medical care program for the Indian Health Service or of a tribal organization; (vii) a state health benefits risk pool (as defined in regulations); (viii) a health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program); (ix) a public health plan (as defined in regulations); (x) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)); or (xi) Title XXI of the Social Security Act (State Children’s Health Insurance Program).

(b) Creditable Coverage does not include the following: (i) coverage only for accident or disability income insurance, or any combination thereof; (ii) coverage issued as a supplement to liability insurance; (iii) liability insurance, including general liability insurance and automobile liability insurance; (iv) workers’ compensation or similar insurance; (v) automobile medical payment insurance; (vi) credit-only insurance; (vii) coverage for on-site medical clinics; (viii) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits; (ix) limited scope dental or vision benefits, benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, and such other similar, limited benefits as are specified in regulations; provided that such benefit is offered under a separate policy, certificate or contract of insurance or not an integral part of a HIPAA Program; (x) coverage only for a specified disease or illness, and employer indemnity or other fixed indemnity insurance; provided that the benefit is offered under a separate policy, certificate, or contract of insurance, there is no coordination between provision of such benefits and any exclusion of benefits under a HIPAA Program; and such benefits are paid without regard to whether benefits are provided under such program; or (xi) if offered as a separate insurance policy, Medicare supplemental health insurance (as defined under Section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code, or similar supplemental coverage provided to coverage under a group health plan.

2.16 Dependent.

(a) Unless otherwise set forth in the applicable Program Document or specifically designated for a particular Participating Program in this Section 2.16, the following individuals are “Dependents” under the Plan:

- (i) The Eligible Employee’s Spouse,
- (ii) The Eligible Employee’s Domestic Partner,
- (iii) The Eligible Employee’s, Spouse’s or Domestic Partner’s Children until they attain age 26, and
- (iv) The Eligible Employee’s, Spouse’s, or Domestic Partner’s Fully Handicapped Children.

(b) For any period of time that the Medical Participating Program (or any underlying medical coverage option) is intended to be a grandfathered health plan under PPACA, an Eligible Employee’s, Spouse’s or Domestic Partner’s Child shall not be a Dependent under the Medical, Dental and Vision Participating Programs if the Child is eligible for employer-sponsored health coverage other than the Child’s parent’s health coverage.

(c) Notwithstanding subsection (a) above and unless otherwise set forth in the applicable Program Document, for the Health Care Flexible Spending Account Program, Dependents include the Eligible Employee’s spouse (as determined under federal tax law), the Eligible Employee’s Children (to the extent such Children meet the definition in Code Section 152(f)(1)) who as of the end of the taxable year have not attained age 27, and any other individual (including a Domestic Partner or Child of a Domestic Partner) who meets the Code Section 152 definition of dependent, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof.

(d) Notwithstanding subsection (a) above and unless otherwise set forth in the applicable Program Document, for the Dependent Day Care Flexible Spending Account Program, Dependents include “qualifying individuals” determined in accordance with Section 21(b)(1) of the Code, (i) an Eligible Employee’s qualifying child, as defined in Section 152(a)(1) of the Code, who has not attained age 13, (ii) an Eligible Employee’s dependent, as defined in Section 152 of the Code (determined without regard to subsections (b)(1), (b)(2), (d)(1)(B)), who is physically or mentally incapable of caring for himself and who has the same principal place of abode as the Participant for more than one-half of the taxable year, and (iii) an Eligible Employee’s Spouse who is physically or mentally incapable of caring for himself and who has the same principal place of abode as the Participant for more than one-half of the taxable year.

(e) Notwithstanding subsection (a) above, for the LTC Participating Program, Dependents include the Eligible Employee’s Spouse, surviving spouse, Domestic Partner (except Domestic Partners who live in Louisiana), parents, parents-in-law, grandparents, and grandparents-in-law.

(f) Other than under the Life and Accident Participating Programs, a Participant may not be covered under the Plan as both an Eligible Employee and a Dependent.

(g) Notwithstanding any provision of the Plan to the contrary, (i) no individual may be a Dependent of more than one Employee, (ii) an Eligible Employee's (or his or her Spouse's or Domestic Partner's) parents and grandparents are not Dependents (except as permitted under the LTC Participating Program or as specifically provided under a Program Document), and (iii) children of an Eligible Employee's Child are not Dependents.

2.17 Dental Participating Program. "Dental Participating Program" means the program option(s) providing dental benefits (as set forth in the Program Documents listed in Supplement A, as amended from time to time) that are incorporated herein and form a part of this Plan.

2.18 Dependent Day Care Flexible Spending Account. "Dependent Day Care Flexible Spending Account" means an Account maintained for a Participant under the Dependent Day Care Flexible Spending Account Program that is subject to the general rules set forth in Article VIII of the Plan, from which the Participant is reimbursed for his or her expenses that would qualify as "dependent care assistance" within the meaning of Section 129 of the Code.

2.19 Dependent Day Care Flexible Spending Account Program. "Dependent Day Care Flexible Spending Account Program" means the program (as described in Article VIII and set forth in the Program Documents listed in Supplement A, as amended from time to time) under which the Dependent Day Care Flexible Spending Accounts are maintained.

2.20 Domestic Partner. "Domestic Partner" means an adult of either gender with whom an Eligible Employee has engaged in a relationship that satisfies one of the following criteria:

(a) The Eligible Employee and same-sex adult are lawfully married pursuant to a state or foreign law permitting same-sex marriages;

(b) The Eligible Employee and his or her partner are registered as domestic partners or civil union partners through a governmental domestic partnership registry or under an applicable civil union law; or

(c) The Eligible Employee and his or her partner are registered as domestic partners, pursuant to procedures established by the Company, by satisfying all of the following criteria:

(i) The Eligible Employee and his or her partner have shared a primary residence for at least six (6) months and are responsible to each other for the direction and management of the household;

(ii) The Eligible Employee and his or her partner are both legally entitled to reside in the household under applicable immigration laws;

(iii) The Eligible Employee and his or her partner have a committed relationship of mutual caring which has existed for at least six (6) months prior to enrollment in any of the Participating Programs under the Plan;

(iv) The relationship between the Eligible Employee and his or her partner is expected to be long-term;

(v) The Eligible Employee and his or her partner are both 18 years of age or older and are mentally competent;

(vi) Neither the Eligible Employee nor his or her partner is married or has another domestic partner;

(vii) The Eligible Employee and his or her partner are not blood relatives; and

(viii) The Eligible Employee and his or her partner have not been married to each other at any time within the past twelve (12) months.

2.21 Effective Date. “Effective Date” means January 1, 2014.

2.22 Eligible Employee. Unless otherwise set forth in the applicable Program Document or specifically designated for a particular Participating Program in this Section 2.22:

(a) “Eligible Employee” means any Employee who (i) either lives in the United States or is a United States expatriate or United States benefits-eligible international employee who in either case receives pay from a United States dollar-based payroll, and (ii) classified (according to the Company’s Employee Classification Policy) as a full-time employee, a flex part-time employee, a regular part-time employee, an employee working in Hawaii 20 hours or more per week for four consecutive weeks earning at least 86.67 times the current minimum wage (subject to Hawaii Department of Labor regulations), or a former retiree who was covered under the Discover Financial Services Retiree Welfare Benefits Plan on the day before being rehired as a full-time, flex part-time or regular part-time employee and is regularly scheduled to work more than 10 hours per week.

(b) The term “Eligible Employee” shall not include (i) an Employee who is classified (according to the Company’s Employee Classification Policy) as a part-time, prime-time or temporary employee, or (ii) an Employee who is classified (according to the Company’s Employee Classification Policy) as a “non-benefits-eligible” worker, including, but not limited to, an intern, a summer associate, or a contingent worker.

(c) The determination of whether an Employee is an Eligible Employee under the criteria described in subsection (a) above shall be made by the Plan Administrator in its sole discretion.

(d) Notwithstanding the foregoing, any Employee shall be an Eligible Employee for purposes of the Medical Participating Program under the Plan to the extent

of (and subject to the limitations of) his or her eligibility to participate in any of the Wellness Programs (described in Section 10.12) or the Employee Assistance Program (described in Supplement A), as the eligibility for such Wellness Programs and the Employee Assistance Program is identified and communicated to Employees in the Plan Administrator's sole discretion.

2.23 Employee. "Employee" means any individual employed by a Participating Employer. Notwithstanding the foregoing, "Employee" shall not include the following categories of individuals, even if one or more of such individuals is determined by a court, the Internal Revenue Service or any other entity under any federal or state law, rule or regulation to be (or have been) a common law or statutory employee of a Participating Employer for some or all of the period of time in question:

(a) An individual who is performing services for the Participating Employer under an independent contractor or consultant agreement or arrangement with the Participating Employer;

(b) An individual who must be treated as an employee of the Participating Employer for limited purposes under the leased employee provisions of Section 414(n) of the Code;

(c) An individual covered by a collective bargaining agreement with respect to which a Participating Employer is a party that does not specifically provide for participation in the Plan, provided the type of benefits provided under the plan were the subject of good faith bargaining between the individual's bargaining representative and the Participating Employer; and

(d) An individual hired in connection with an acquisition agreement entered into on or after January 1, 2008, unless such agreement specifically provides for participation in the Plan.

2.24 ERISA. "ERISA" means the Employee Retirement Income Security Act of 1974, as amended, and the regulations thereunder.

2.25 Flexible Benefit Options. "Flexible Benefit Options" means the benefit coverage options available to be purchased or provided through the flexible benefit arrangement portion of the Plan. As of the Effective Date, the Flexible Benefit Options are (a) the cost of coverage under a Pre-Tax Component Program, (b) the cost of HSA Contributions, and (c) cash. The flexible benefit arrangement portion of the Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Code.

2.26 FMLA. "FMLA" means the Family and Medical Leave Act of 1993 and applicable regulations issued and effective thereunder.

2.27 Fully Handicapped. For purposes of the Medical, Dental and Vision Participating Programs and the supplemental insurance under the Life Participating Program, "Fully Handicapped" means a Child (a) who is not able to earn a living because of a mental or physical handicap that began prior to the date the Child reached age 26 and (b) who depends primarily on

the Eligible Employee or another care provider (*i.e.*, a community integrated living arrangement, a group home, a supervised apartment or other residential services licensed or certified by a state department of health) for support. At its sole discretion, the Plan Administrator may require the Eligible Employee to provide any documentation necessary or the Plan Administrator may retain the services of a physician to examine the Child in order to confirm the Child's continued handicap after attaining age 26.

2.28 Health Care Flexible Spending Account. "Health Care Flexible Spending Account" means an Account maintained for a Participant under the Health Care Flexible Spending Account Program that is subject to the general rules set forth in Article VI of the Plan, from which the Participant may be reimbursed for medical expenses for the treatment of the Participant and his or her Dependents, provided that such expenses have been incurred and are of a type that is eligible for reimbursement as described under Section 6.6 of the Plan and applicable law.

2.29 Health Care Flexible Spending Account Program. "Health Care Flexible Spending Account Program" means the program (as described in Article VI and set forth in the Program Documents listed in Supplement A, as amended from time to time) under which the Health Care Flexible Spending Accounts are maintained. The Health Care Flexible Spending Account Program includes the Limited Purpose Flexible Spending Account (as described in Section 7.7 of the Plan), and all references to the Health Care Flexible Spending Account Program in the Plan (except such references under Articles VI and IX of the Plan unless otherwise noted in Section 7.7 of the Plan) shall apply to and include the Limited Purpose Flexible Spending Account.

2.30 Health Savings Account. "Health Savings Account" or "HSA" means a health savings account established under Section 223 of the Code. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Eligible Employee with a qualified trustee or custodian.

2.31 Hearing Panel. "Hearing Panel" means the Discover Hearing Panel or such other individual or committee designated by the Plan Administrator to review appeals of eligibility determinations under a particular Participating Program.

2.32 High Deductible Health Plan. "High Deductible Health Plan" means a health plan benefit option offered by the Company that is intended to qualify as a high deductible health plan under Section 223(c)(2) of the Code.

2.33 HIPAA. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, including the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), as incorporated in the American Recovery and Reinvestment Act of 2009, and the regulations thereunder.

2.34 HIPAA Program. "HIPAA Program" means a Participating Program subject to the portability and administrative simplification requirements of HIPAA, as required by Section 9801(f) of the Code.

2.35 HRA. “HRA” means a health reimbursement arrangement within the meaning of Internal Revenue Service Notice 2002-45 and other related guidance and a “self-insured medical reimbursement plan” under Sections 105 and 106 of the Code.

2.36 HSA Contributions. “HSA Contributions” means the contributions to a Health Savings Account described in Section 7.2 made through this Plan.

2.37 HSA-Eligible Individual. “HSA-Eligible Individual” means a Participant who, as determined and reported to the Plan Administrator by the Participant, is eligible to contribute to a Health Savings Account under Section 223 of the Code and who has elected qualifying High Deductible Health Plan coverage offered by the Company, and who: (a) is not also covered by any other health plan that is not a High Deductible Health Plan, (b) is not enrolled in Medicare, and (c) may not be claimed as a dependent on another person’s tax return. The determination as to whether a Participant is an HSA-Eligible Individual shall be made by each respective Participant.

2.38 Independent Review Organization or IRO. “Independent Review Organization” or “IRO” means an entity that is accredited by URAC or by a similar nationally-recognized accrediting organization that conducts independent external reviews of Adverse Benefit Determinations as set forth in PPACA (and described in Section 11.5).

2.39 Leave of Absence. “Leave of Absence” shall have the meaning provided under the terms of the applicable Program Document for a Participating Program.

2.40 Legal Assistance Participating Program. “Legal Assistance Participating Program” means the legal assistance program (as set forth in the Program Documents listed in Supplement A, as amended from time to time) that is incorporated herein and forms a part of this Plan.

2.41 Life Participating Program. “Life Participating Program” means the life insurance benefit program (as set forth in the Program Documents listed in Supplement A, as amended from time to time) that is incorporated herein and forms a part of this Plan.

2.42 Limited Purpose Flexible Spending Account. “Limited Purpose Flexible Spending Account” means an account maintained for a Participant under the Health Care Flexible Spending Account Program, but subject to the rules set forth in Section 7.7 of the Plan and applicable law, from which the Participant may be reimbursed for medical expenses incurred after the minimum annual deductible under the High Deductible Health Plan is satisfied and vision, dental and preventive care expenses, provided such expenses are of a type that is eligible for reimbursement as described under Section 7.7 of the Plan and applicable law.

2.43 LTC Participating Program. “LTC Participating Program” means the long-term care insurance benefit program (as set forth in the Program Documents listed in Supplement A, as amended from time to time) that is incorporated herein and forms a part of this Plan. The LTC Participating Program shall not include long-term care insurance policies that were issued prior to April 15, 2004, and long-term care insurance policies will no longer be issued under the LTC Participating Program after August 1, 2011.

2.44 LTD Participating Program. “LTD Participating Program” means the long-term disability benefit program (as set forth in the Program Documents listed in Supplement A, as amended from time to time) that is incorporated herein and forms a part of this Plan.

2.45 Medical Participating Program. “Medical Participating Program” means any program providing medical and prescription drug benefits (as set forth in the Program Documents listed in Supplement A, as amended from time to time) that is incorporated herein and forms a part of this Plan.

2.46 Medicaid. “Medicaid” means the program originally set forth in Title XIX of the Social Security Act of 1965, as then constituted and later amended.

2.47 Medicare. “Medicare” means the Health Insurance for the Aged and Disabled Program under Title XVIII of the Social Security Act of 1965, as then constituted and later amended.

2.48 Participant. “Participant” means the term as defined in Section 3.1 of the Plan.

2.49 Participating Employer. “Participating Employer” means the Company and each other corporation that is a member of the same controlled group of corporations (within the meaning of Code Section 414(b)) as the Company, unincorporated trade or business that is under common control with the Company (within the meaning of Code Section 414(c)), organization that is a member of an affiliated service group (within the meaning of Code Section 414(m)) of which the Company is also a member, and entity required to be aggregated with the Company under Code Section 414(o) that participates in the Plan. The Participating Employers for the Plan are listed in Supplement C. The Company reserves the right to amend Supplement C at any time to reflect changes to the list of Participating Employers.

2.50 Participating Program. “Participating Program” means a welfare benefit program that forms a part of this Plan as set forth in the Program Documents listed in Supplement A, as amended from time to time.

2.51 Plan. “Plan” means the Discover Financial Services Welfare Benefits Plan as set forth under this document, including the Program Documents for the Participating Programs that are incorporated by reference in Supplement A.

2.52 Plan Administrator. “Plan Administrator” means the individual or committee appointed by the Compensation Committee of the Company’s Board of Directors (currently the Discover Financial Services Employee Benefits Committee) or any delegate of such individual or committee.

2.53 Plan Sponsor. “Plan Sponsor” means the Company and any successor or assign thereof that adopts the Plan by action of its governing body or that contractually assumes the obligations of the Company under the Plan.

2.54 Plan Year. “Plan Year” means the 12-month period beginning on January 1st and ending on December 31st.

2.55 PPACA. “PPACA” means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, and the regulations thereunder.

2.56 Pre-Tax Component Program. “Pre-Tax Component Program” means, subject to the limitations of Section 125 of the Code, any Participating Program that provides coverage to the Eligible Employee and is selected by the Company as eligible for pre-tax payment of contributions under the Plan. The Company shall designate the Participating Programs to be treated as Pre-Tax Component Programs under the Plan, and such designations shall be listed in Supplement B attached hereto.

2.57 Program Document. “Program Document” means the written description of the terms of each separate Participating Program, including but not limited to a summary plan description, summaries of material modifications, schedule of benefits, benefits booklet, or insurance contract, policy or certificate. The Program Documents are listed in Supplement A, as amended from time to time.

2.58 Qualified Life Event. “Qualified Life Event” means an event that permits an Eligible Employee to change his coverage elections under the Plan and/or Participating Program(s) in accordance with Section 5.4 and the applicable Program Documents.

2.59 Required Contribution. “Required Contribution” means the Participant’s weekly (or such other frequency as determined by the Plan Administrator) contribution for the Participating Programs (including any Flexible Benefit Option(s)) elected by the Participant under Article V for the Plan Year. “Required Contributions” shall also include, to the extent applicable, the amount of HSA Contributions that a Participant elects to make under Section 7.2, subject to the limitations set forth in Section 7.3.

2.60 Spouse. Effective September 16, 2013, “Spouse” means an individual lawfully married to an Eligible Employee under the laws of any domestic or foreign jurisdiction where such individual and Eligible Employee were married.

2.61 STD Participating Program. “STD Participating Program” means the short-term disability benefit program (as set forth in the Program Documents listed in Supplement A, as amended from time to time) that is incorporated herein and forms a part of this Plan.

2.62 Supplement. “Supplement” means the supplements that are attached to and form a part of this Plan document. From time to time, Supplements may be added for purposes of modifying provisions of the Plan or for adding or terminating Participating Programs and/or Participating Employers under the Plan.

2.63 USERRA. “USERRA” means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and the regulations thereunder.

2.64 Vision Participating Program. “Vision Participating Program” means the program option(s) providing vision benefits (as set forth in the Program Documents listed in Supplement A, as amended from time to time) that are incorporated herein and form a part of this Plan.

ARTICLE III

ELIGIBILITY AND PARTICIPATION

3.1 Participation. Unless otherwise set forth in the applicable Program Document:

(a) “Participant” means (i) any Eligible Employee who elects to participate in a Participating Program in accordance with its terms and conditions and has not for any reason become ineligible to participate further in that Participating Program, (ii) any former Employee of a Participating Employer who is entitled to benefit payments or to continue participation under a Participating Program, and (iii) any Dependents of the Eligible Employee who are properly enrolled in the Participating Program. Except as discussed in this Article III, the participation policy for each Participating Program is found in the applicable Program Document.

(b) An Eligible Employee will become a Participant in a Participating Program upon satisfying the conditions set forth in the applicable Program Document, provided, however, that in no event shall an Eligible Employee or his Dependent(s) become Participants in the Plan before the Eligible Employee has submitted a valid, executed election and salary reduction agreement to the Plan Administrator in accordance with Article V of the Plan (except to the extent such election and agreement is not required under Section 5.1(d)).

(c) An Eligible Employee must notify the Plan Administrator immediately if his or her covered Dependent ceases to be a Dependent under the terms of the Plan or a Participating Program. The Plan Administrator may require proof of an individual’s eligibility as a Dependent such as a marriage license, birth certificate or adoption document at any time. Failure to provide such requested proof will result in the Dependent’s ineligibility to enroll under Article V, or termination of a Dependent’s participation as set forth in Section 3.2(g).

(d) Notwithstanding the foregoing or any provision of the Plan to the contrary, Eligible Employees with respect to the Wellness Programs and the Employee Assistance Program (described in Section 2.22(d)) and any dependents of such Eligible Employees who are eligible to participate in any Wellness Program and/or the Employee Assistance Program (according to the eligibility for such dependents as identified and communicated to Employees in the Plan Administrator’s sole discretion) but who do not otherwise meet the requirements for Plan participation under subsections (a), (b) or (c) of this Section 3.1 shall nevertheless be “Participants” in the Plan under the Medical Participating Program, but only with respect to and to the extent of their participation in the Wellness Program(s) and/or the Employee Assistance Program.

3.2 Termination of Participation. Participation in the Plan will cease for a Participant upon the earliest of the following, except to the extent specifically provided otherwise in a Program Document or under applicable law:

(a) the last day of the month in which the Participant ceases to be an Employee, an Eligible Employee, or a Dependent (except to the extent continuation coverage is available under COBRA);

(b) the first day of a period for which Required Contributions (except HSA Contributions) for the Participant's coverage have not been made;

(c) the first day after the Participant elects to not participate in any Participating Program (in accordance with Sections 5.1 and 5.4);

(d) the date of the Participant's death;

(e) for Dependents, the date of the Eligible Employee's death (except as provided under Section 3.4);

(f) for a Dependent who is a Fully Handicapped Child, the first to occur of (i) the cessation of the Child's handicap or dependency, (ii) 60 days after proof of the handicap or dependency was requested by the Plan Administrator and was not provided, or (iii) termination of coverage as a Dependent for any reason other than reaching the maximum age;

(g) the date a Participant fails to provide the Plan Administrator with the information necessary to determine an individual's status as a Dependent within the time period specified by the Plan Administrator for the Participant to provide such information; or

(h) the date the Plan terminates or is amended in a manner that it no longer applies to the Participant.

With respect to any particular Participating Program, participation in such Participating Program will cease for a Participant upon the earlier of the date that coverage under the Participating Program for such Participant is waived in accordance with the terms of the Plan, or the date the Participant is no longer eligible for such Participating Program (as set forth in the Program Document).

3.3 Rescission of Coverage. Under the Medical Participating Program, a cancellation or discontinuance of coverage that has a retroactive effect (e.g., a cancellation that either treats a policy as void from the time of the Participant's enrollment, or voids benefits paid up to a year before the cancellation) is allowable under the Plan only (a) if the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay Required Contributions, or (b) under PPACA or any other applicable guidance issued thereunder, such cancellation or discontinuance of coverage is not considered to be a prohibited rescission. The Plan may rescind a Participant's coverage under the Plan if the Participant performs an act, practice, or omission that constitutes fraud in an enrollment form or in a claim for benefits, or makes an intentional misrepresentation of material fact to the Plan Administrator regarding any information material to the Participant's eligibility for benefits. The Plan Administrator shall provide at least 30 days advance written notice to the Participant if the Participant would be

affected before coverage will be rescinded. Any rescission of coverage shall be treated as an Adverse Benefit Determination.

3.4 Continuation of Participation After Death. Notwithstanding Section 3.2 or any other provision of the Plan to the contrary, in the event a Participant who is an Eligible Employee dies while he or she is an active Employee, the Participant's Dependents shall continue to receive coverage under the Medical, Dental and Vision Participating Programs as in effect immediately prior to the Participant's death. Such participation by the Participant's Dependents shall remain in effect for a period of one (1) year following the Participant's death and the Required Contributions (except any HSA Contributions) for such coverage shall be paid by the Company. At the end of such one (1) year period, the Participant's Dependents may elect to continue their participation in the Medical, Dental and/or Vision Participating Programs thereafter as may be available under COBRA. A Dependent's eligibility for continued coverage under any Participating Program, other than the Medical, Dental and Vision Participating Programs, following the death of an Eligible Employee shall be determined in accordance with the applicable Participating Program.

3.5 Continuation of Participation After Involuntary Termination. Notwithstanding Section 3.2 or any other provision of the Plan to the contrary, in the event a Participant terminates employment with the Participating Employers due to an involuntary termination without cause, the Participant's (and his Dependents, if applicable) basic and supplemental coverage under the Life Participating Program may continue at no cost following the Participant's termination date, provided the Participant (a) has been covered under the Life Participating Program for at least one year, (b) has not reached age 60 on the date of his termination of employment, and (c) has not converted his coverage to an individual policy. Such coverage under the Life Participating Program shall continue for a period equal to one month for each year that the Participant has been covered under the Life Participating Program (up to a maximum of three months), and the amount of this continued coverage shall be the amount of the life insurance in effect on the Participant's termination date.

3.6 Continuation of Participation During Leaves of Absence. To the extent permitted in the applicable Participating Program, an Eligible Employee taking a paid or unpaid Leave of Absence (including while receiving disability benefits under the STD or LTD Participating Programs) may continue to participate in the Participating Program using the benefit election that is in effect on the day immediately preceding the first day of such leave; provided, however, that to the extent permitted under Section 5.4, the Eligible Employee may modify his or her coverage election(s) in connection with an unpaid Leave of Absence. Notwithstanding the foregoing, an Eligible Employee will be allowed to maintain coverage under the Plan while on a Leave of Absence only for the period of time permitted under the Participating Program; and provided that the Eligible Employee maintains his or her eligibility to participate in the applicable Participating Program and makes all Required Contributions. An Eligible Employee taking an unpaid Leave of Absence who elects to continue his or her participation during such leave shall pay his or her Required Contributions during the Leave of Absence on an after-tax basis by remitting the Required Contributions to the Plan Administrator in accordance with the procedures established by the Plan Administrator. Notwithstanding the foregoing, the Eligible Employee shall not be required to continue his or her HSA Contributions during a Leave of Absence.

3.7 Participation Upon Reinstatement Following a Revocation of Participation.

(a) Rehire. Except as otherwise provided in an applicable Participating Program, if an Eligible Employee terminates employment or is employed in an employment status not eligible for benefits under the Plan and (i) at least 31 calendar days later or in a subsequent calendar year, such individual is re-employed or re-classified by a Participating Employer as an Eligible Employee, then such individual shall be treated as a new Eligible Employee for purposes of the Plan and shall be eligible for and may become enrolled in the Plan in accordance with Sections 3.1 and 5.1 (provided any such coverage elections are made within 31 days of the date the individual is re-employed or re-classified as an Eligible Employee); or (ii) within 31 calendar days and the same calendar year, such individual is re-employed or re-classified by a Participating Employer as an Eligible Employee, then such individual shall be re-enrolled as a Participant in accordance with the individual's benefit coverage election(s) in effect immediately prior to such individual's termination of employment or loss of benefit eligible status.

(b) Unpaid Leave of Absence. Except as otherwise provided in an applicable Participating Program, if an Eligible Employee revokes his or her participation upon the taking of an unpaid Leave of Absence and is reinstated with a Participating Employer as an Eligible Employee (i) at least 31 calendar days later or in a subsequent calendar year, then such individual shall be treated as a new Eligible Employee for purposes of the Plan and shall be eligible for and enrolled in the Plan in accordance with Sections 3.1 and 5.1; or (ii) within 31 calendar days and the same calendar year, then such individual shall be re-enrolled as a Participant in accordance with the individual's benefit coverage election(s) in effect immediately prior to such individual's unpaid Leave of Absence.

(c) FMLA Leave of Absence. In the event an Eligible Employee's coverage under the Health Care Flexible Spending Account Program does not continue during FMLA leave (because the Eligible Employee chooses to revoke coverage or does not pay the Required Contributions for any reason during FMLA leave), upon returning from FMLA leave within the same Plan Year, the Eligible Employee will have a choice between:

(i) resuming coverage at the original level and making up the unpaid Required Contributions (except HSA Contributions); or

(ii) resuming Required Contributions at the level that was in effect immediately prior to the Leave of Absence and resuming coverage under the Health Care Flexible Spending Account Program at a level that is equal to the Eligible Employee's original coverage, reduced by (A) the amount of contributions missed during the leave and (B) the amount of any prior reimbursements paid to the Eligible Employee.

In any event, if the Plan has already made disbursements to the Eligible Employee that exceed the Required Contributions that will be paid for the Plan Year under the

Health Care Flexible Spending Account Program, the Eligible Employee will not be required to pay any more than the remaining Required Contributions due.

ARTICLE IV

GENERAL TERMS OF THE PLAN

4.1 Insuring and Funding Benefits. Funding for the Plan will consist of an aggregation of the funding for all Participating Programs and may include funding through insurance contracts, through the general assets of the Company and/or other Participating Employers, through a trust, through Participants' contributions, or through any combination thereof. The Company will have the right to insure any benefits under the Plan or to establish any fund or trust for the payment of benefits under the Plan either as mandated by law or as the Company deems advisable. If any benefit is funded by the purchase of insurance, the benefit will be payable solely by the insurer. To the extent funds are transferred to a trust to provide any benefit, that benefit will be payable from the assets of such trust. The Plan Sponsor will not have any further responsibility to pay such benefit. Anything in the Plan or a Participating Program to the contrary notwithstanding, no funding arrangement which is established to provide for a specific Participating Program shall be used to provide benefits under any other Participating Program. The costs of Plan benefits will be funded in part by contributions from the Participating Employers and in part by Participants' Required Contributions. The Plan Sponsor, in its sole discretion, will from time to time establish and communicate the cost of the benefits to be provided under the Plan and the Participants' Required Contributions.

4.2 Benefits, Limitations and Termination of Rights to Benefits. The benefits available under the Plan will consist of an aggregation of the benefits available under each Participating Program in which a Participant is eligible to participate, including all limitations and exclusions with respect to each Participating Program's benefits. The benefits available under each Participating Program and the limitations with respect to such benefits are set forth in the applicable Program Document identified in Supplement A. A Participant's right to benefits under this Plan will be dictated by and limited to his or her right to benefits under each Participating Program in which the Participant participates. Any termination or cessation of a Participant's rights or coverage under a Participating Program will be considered a termination or cessation of those same rights or coverage with respect to that Participating Program under the Plan. The Plan provides for no rights other than those provided for under each Participating Program. No Participant in the Plan or Participating Programs or any other individual has a vested right to any benefits under the Plan or any Participating Program.

4.3 Participant Contributions Required for Plan Coverage. The Company will determine whether and the extent to which any of the Participating Programs will require Participants to contribute toward the cost of coverage. The Company will establish the Required Contributions (or any maximum amount that may be elected by Participants' for their Required Contributions) applicable to Participants under the applicable Participating Programs and, in its sole discretion, may adjust such Required Contributions (or maximum amount of Required Contributions that may be elected) from time to time and will determine whether such costs may be paid by the Participants on a pre-tax or an after-tax basis. Further, the Company may adjust the level of Required Contributions for a Participant based on the Participant's participation in a

Wellness Program (described in Section 10.12). Participants who are Employees will be required to make such Required Contributions under the Participating Programs elected under the Plan by automatic reduction of the Participant's Compensation on a pre-tax or after-tax basis, as applicable. The Company will track the Participant's Required Contributions and apply them toward the cost of coverage of the applicable Participating Program(s) or as specifically elected by the Participant. The balance of the cost of a Participating Program, if any, will be paid by the Participating Employer(s). To the extent a Participating Employer contributes to the cost of coverage under a Participating Program for an Eligible Employee's Dependent who is not the Eligible Employee's tax-qualified dependent for purposes of that Participating Program, the Company shall impute income to the Eligible Employee in the amount of the value of the coverage for the Dependent, as determined in the Plan Administrator's sole discretion.

4.4 Payment of Benefits. The benefits under the Plan will be payable according to the payment policies of each Participating Program. Benefits will be paid from an insurance contract, the general assets of the Company and/or other Participating Employers, or a trust, or through any combination thereof, as is appropriate under the applicable Participating Program.

4.5 Inspection of Documents. This Plan document and the Program Documents listed in Supplement A will be available for inspection during normal business hours at the offices of the Plan Sponsor or other reasonable location designated by the Plan Administrator.

4.6 Facility of Payment. When a Participant is under a legal disability or in the opinion of the Plan Administrator or the Claims Administrator is in any way incapacitated so as to be unable to manage his financial affairs, the Company, Plan Administrator or Claims Administrator may make benefit payments to the Participant's legal representative. If a legal representative has made no claim, benefit payments may be made to a relative or close friend of the Participant for the Participant's benefit. Any payments made in accordance with this Section 4.6 will be a full and complete discharge of any liability for such payment under the Plan and the applicable Participating Program.

4.7 Evidence. Evidence required by the Company, Plan Administrator or Claims Administrator under a Participating Program may be by certificate, affidavit, document or other information that the person acting on it considers pertinent and reliable, provided that the document is signed, made or presented by the proper party(ies).

4.8 Plan Expenses. Except as otherwise provided in the underlying Program Documents, no assets of any Participating Program will inure to the Company; instead, such assets will be used exclusively to provide benefits under the Participating Programs and to defray reasonable fees and expenses incurred in connection with the operation and administration of the Participating Programs or the Plan. All fees and expenses incurred in connection with the operation and administration of the Plan, including legal, accounting, actuarial, investment, trustee, management and administrative fees and expenses may be paid out of any trust or Plan assets to the extent legally permitted. The Plan Sponsor may advance amounts properly payable by the Plan or trust and then obtain reimbursement from the Plan or any trust thereunder.

4.9 Uniform Rules. The Plan Administrator and each Claims Administrator will administer the Plan and Participating Programs on a reasonable and nondiscriminatory basis and will apply uniform rules to all similarly situated Participants.

4.10 Unclaimed Self-Funded Plan Funds. Except as otherwise specified in a Participating Program, in the event a benefits check issued by the Claims Administrator or Plan Administrator under a self-funded Participating Program remains uncashed after one (1) year, the check will be voided and the funds will be returned to the Participating Program to be applied to the payment of current benefits and administrative fees under the Participating Program. In the event the Participant or the Participant's beneficiary (as defined under ERISA) subsequently requests payment with respect to the voided check, the Claims Administrator or Plan Administrator for the applicable Participating Program will make such payment under the terms and conditions of that Participating Program as in effect when the claim was originally presented, provided any such request is made by the earlier of three (3) years following the date the benefits check was issued, or the end of any applicable statutory limitations period. If the Participant or the Participant's beneficiary does not make such request within the applicable time period set forth in the preceding sentence, the Participant or Participant's beneficiary shall be barred from receiving payment with respect to the voided check.

ARTICLE V

FLEXIBLE BENEFIT ARRANGEMENT TERMS

5.1 Enrollment.

(a) Initial Enrollment. On (or within a reasonable time after) the date an Employee becomes an Eligible Employee, the Plan Administrator shall provide to such Employee a description of the Participating Programs in which the Employee is (or will be) eligible to participate and the procedures (including any necessary forms) that the Employee must follow to enroll himself and/or his Dependents (if applicable) for coverage under such Participating Programs. Such Eligible Employee may elect coverage for himself and/or his Dependents (if applicable) under the applicable Participating Program(s) within 31 days (or 90 days for the LTC Participating Program) of the date the enrollment materials described in the preceding sentence are sent to the Eligible Employee. An Eligible Employee may enroll a new eligible Dependent in accordance with the provisions of Section 5.4. However, in the case of an Eligible Employee who is enrolled in the family level of coverage under the Medical Participating Program, Dental Participating Program and/or Vision Participating Program, a newborn child, adopted child, or child placed with the Eligible Employee for adoption will be automatically enrolled in the Participating Program(s) in which the Eligible Employee is enrolled in the family level of coverage; provided that the Eligible Employee notifies the Plan Administrator of the child's birth, adoption, or placement for adoption and elects to enroll such child in the applicable Participating Program(s) within 90 days of the child's birth or adoption. In the case of an Eligible Employee who is enrolled in any level of coverage other than family coverage under the Medical Participating Program, Dental Participating Program and/or Vision Participating Program, a newborn child, adopted child, or child placed with the Eligible Employee for adoption may be enrolled in the

Participating Program(s) as requested; provided that the Eligible Employee notifies the Plan Administrator of the child's birth, adoption or placement for adoption and elects to enroll such child in the applicable Participating Program(s) within 31 days of the child's birth, adoption or placement for adoption. If the Eligible Employee notifies the Plan Administrator after 31 days, the Eligible Employee must file a claim requesting such coverage to the Claims Committee within 90 days of the child's birth, adoption or placement for adoption in order for the child to be enrolled in the applicable Participating Program(s).

Notwithstanding the foregoing, an Eligible Employee may elect coverage for his Domestic Partner within 31 days of the date such individual became a Domestic Partner. The Eligible Employee's election shall be either to participate in the Plan and one or more Participating Programs hereunder or to waive participation in the Plan and one or more Participating Programs hereunder, pursuant to the procedures established by the Plan Administrator. The procedures for an Eligible Employee to elect coverage for himself and/or his Dependents (if applicable) under the Participating Programs shall be established in the discretion of the Plan Administrator.

Notwithstanding the foregoing to the contrary, the following enrollment terms apply to an Eligible Employee's election under the Life Participating Program:

(i) An Eligible Employee must be actively working for a Participating Employer on the day he or she enrolls in coverage; and

(ii) An Eligible Employee's election made under the Life Participating Program is effective as of the later of (a) the date the Employee becomes eligible under the Life Participating Program, or (b) the date the Employee elects benefits under the Life Participating Program.

(b) Annual Enrollment. Prior to each Plan Year, each Eligible Employee who is eligible to participate in the Plan as of the start of the next Plan Year shall be furnished with enrollment materials or otherwise be given the opportunity (in a manner to be determined by the Plan Administrator) to elect to participate in the Plan and its Participating Programs for that next Plan Year. A current description of the Flexible Benefit Options for which the Employee is eligible shall also be furnished to him or her prior to or at the start of the election period. At annual enrollment, the Eligible Employee shall elect either to participate in the Plan for the next Plan Year or to waive participation in the Plan for that Plan Year, pursuant to procedures established by the Plan Administrator, which may include, in the Plan Administrator's discretion, an automatic renewal of an Eligible Employee's prior year elections as to some or all of the Flexible Benefit Options. The associated Compensation Reduction Amount will be made through payroll deductions during the Plan Year in which the Eligible Employee receives cash compensation from the Employer.

(c) Enrollment Effective Date. The elections an Eligible Employee makes during his initial enrollment period described in subsection (a) above are effective as of his first day of employment, or the first day he became an Eligible Employee, whichever

is later, and the elections an Eligible Employee makes during annual enrollment shall be effective as of the first day of the applicable Plan Year. Notwithstanding the foregoing, elections for participation in the LTC Participating Program shall be effective as of the first of the month following acceptance for such participation, and elections for the Health Care and Dependent Day Care Flexible Spending Account Programs shall apply only to Compensation paid to the Eligible Employee after the elections have been made. Such elections (other than elections under the Health Care and Dependent Day Care Flexible Spending Accounts) shall remain in effect for that Plan Year and each Plan Year thereafter unless modified or revoked in accordance with Section 5.4, or as otherwise modified or revoked in accordance with the terms of the applicable Program Document. An Eligible Employee must re-elect to participate in the Health Care and Dependent Day Care Flexible Spending Account Programs for each Plan Year for which he chooses to participate in such Program(s) during the annual enrollment period designed by the Plan administrator prior to that Plan Year.

(d) Failure to Enroll. If an Eligible Employee does not make any elections under subsection (a) above, such Eligible Employee (but no Dependents) shall be automatically enrolled in the following Participating Programs:

(i) Medical Participating Program (in the plan option designated by the Plan Administrator for such automatic enrollment);

(ii) STD Participating Program;

(iii) LTD Participating Program;

(iv) Life Participating Program (in the amount designated by the Plan Administrator for such automatic enrollment);

(v) Accident Participating Program (in the amount designated by the Plan Administrator for such automatic enrollment); and

(vi) BTA Participating Program.

(e) LTD, Life, Accident, BTA and LTC Participating Programs. Notwithstanding anything in this Article V to the contrary, an Eligible Employee may waive (i.e., not elect) certain coverage options offered under the LTD, Life, Accident and LTC Participating Programs during his initial enrollment period (described in subsection (a)) and then at any subsequent time elect such coverage, provided that the Eligible Employee provides any documentation and follows any procedure that may be required at the discretion of the Plan Administrator or the insurance company administering such coverage.

5.2 Reduction of Compensation. An Eligible Employee may choose under the Plan to receive his or her full Compensation for any Plan Year in cash or to have a portion of it applied to the Required Contributions for any one or more of the Participating Programs (including the Flexible Benefit Options) for which the Employee is eligible and in which the Eligible Employee has elected to participate for the Plan Year.

(a) For purposes of the Pre-Tax Component Program portion of the Plan, a Participant's Compensation will be reduced in an amount equal to the Participant's share of the Required Contribution under the applicable Participating Program. The balance of the cost of each such benefit will be paid by the Participating Employer. Notwithstanding the foregoing, an Eligible Employee who elects family coverage with respect to his or her Dependent(s) may contribute to the cost of family coverage by automatic pre-tax reduction of the Participant's Compensation from the Participating Employer only to the extent that the Dependent(s) is the Employee's spouse, child (as defined in Code Section 152(f)(1)) who as of the end of the taxable year has not attained age 27, or other eligible Dependent who meets the Code Section 152 definition of dependent, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof. Eligible Employee contributions with respect to coverage of a Dependent who is not the Employee's spouse, child (as defined in Code Section 152(f)(1)) who as of the end of the taxable year has not attained age 27, or other eligible Dependent who meets the Code Section 152 definition of dependent, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof will be contributed by automatic post-tax reduction of the Participant's Compensation.

(b) If an Employee elects to participate in the Health Care Flexible Spending Account Program or the Dependent Day Care Flexible Spending Account Program, the Participant's Compensation will be reduced in the amount that the Participant elects to allocate toward the Health Care Flexible Spending Account and/or the Dependent Day Care Flexible Spending Account for the Plan Year, and an amount equal to the reduction will be credited by the Company to the appropriate Flexible Spending Account Program.

(c) If an Employee elects to contribute to a Health Savings Account, the Participant's Compensation will be reduced in the amount that the Participant elects to contribute to a Health Savings Account, subject to the limitations set forth in Section 7.3 and transferred to the Health Savings Account trustee.

(d) An Eligible Employee may elect under the Plan to obtain coverage under the Flexible Benefit Options for which he or she is eligible in accordance with the rules described in Articles V, VI, VII, and VIII, as applicable, and the terms of the underlying Program Documents.

(e) For Participating Program elections that an Eligible Employee makes during his initial enrollment period described in Section 5.1(a), the corresponding Compensation Reduction Amounts shall be deducted from the Eligible Employee's Compensation beginning with the paycheck date next following the date that the Eligible Employee completes the enrollment process for such elections as prescribed by Section 5.1(a). The Compensation Reduction Amount for the first paycheck date next following the date that the Participant completes the enrollment process as prescribed in Section 5.1(a) shall include the Required Contribution(s) for coverage under Participating Programs that becomes effective as of the payroll period including Eligible Employee's first day of employment (or the first day he became an Eligible Employee, if later). Notwithstanding the preceding sentence, Compensation Reduction Amounts for the Health Care and Dependent Day Care Flexible Spending Account Programs shall apply

only to Compensation paid to the Eligible Employee after the elections have been made. The Compensation Reduction Amounts corresponding with elections an Eligible Employee makes during annual enrollment shall begin as of the first paycheck date of the applicable Plan Year.

Notwithstanding the foregoing to the contrary, an Eligible Employee becomes responsible for premium payments under the Life Participating Program as of the effective date of coverage under the Life Participating Program.

5.3 Enrollment for Employees Who Waived or Revoked Participation. Any Employee who is eligible to participate, but who waived or revoked participation previously, may elect to participate in the Plan as of the start of a subsequent Plan Year by enrolling in the manner provided in Section 5.1(b) or pursuant to a Qualified Life Event as provided under Section 5.4.

5.4 Modifying and Revoking Elections. A Participant's elections made according to Section 5.1 may be modified or revoked after the start of the Plan Year only during the annual enrollment period designated by the Plan Administrator, or within 31 days following a Qualified Life Event, if earlier. For purposes of this Section 5.4, the term "Spouse" shall include an Eligible Employee's Domestic Partner. An Eligible Employee who is permitted to change his or her coverage election under a particular Flexible Benefit Option, as described in the underlying Program Document for such Flexible Benefit Option and in accordance with this Section 5.4, may adjust his or her Compensation Reduction Amount under the Plan to reflect such election change. The Plan Administrator shall have the sole discretionary authority to interpret and administer this Section 5.4 and shall establish such administrative rules as may be necessary or desirable for the efficient administration of the Plan. Notwithstanding anything in this Section 5.4 or the Plan to the contrary, an Eligible Employee's election changes relating to a Pre-Tax Component Program shall be subject to the restrictions of Section 125 of the Code, including, but not limited to Treas. Reg. 1.125-4 and any related or subsequent guidance issued by the Internal Revenue Service, and the Plan Administrator or its delegate shall administer this Section 5.4 accordingly.

(a) Qualified Life Events. The following shall be considered Qualified Life Events, and any election change (including any change in the amount of a Participant's Compensation Reduction Amount) made within 31 days following a Qualified Life Event must be consistent with such Qualified Life Event:

(i) With respect to Medical, Dental and Vision Participating Programs and Health Care Flexible Spending Account Program:

(A) Change in Status. An Eligible Employee who experiences a Change in Status that affects his (or a Spouse's or Child's, if applicable) eligibility for coverage under a Participating Program may change his or her coverage election(s) and Compensation Reduction Amount under the Plan to correspond with such Change in Status.

(B) Medicare or Medicaid Entitlement. An Eligible Employee may change his coverage election(s) and Compensation Reduction Amount under the Plan to cancel coverage under the Medical Participating Program for the Eligible Employee (or his Spouse or Child), if such individual becomes entitled to coverage under the Medicare or Medicaid programs. An Eligible Employee may also change his coverage election(s) under the Medical Participating Program and increase his Compensation Reduction Amount to provide coverage under the Medical Participating Program for the Eligible Employee, his Spouse, or his Child if the Eligible Employee, Spouse or Child loses eligibility for Medicare or Medicaid coverage.

(C) Special Enrollment. An Eligible Employee may change his or her coverage election(s) and Compensation Reduction Amount under the Plan, provided that the change corresponds with a special enrollment right that the Eligible Employee or the Eligible Employee's Spouse or Child has under the Health Insurance Portability and Accountability Act of 1996 or the Children's Health Insurance Program Reauthorization Act of 2009.

(D) Judgment, Decree or Order Regarding Care for Child. If a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (which is a "qualified medical child support order" under Section 609 of ERISA) requires an Eligible Employee to provide health coverage for a child, the Eligible Employee may change his coverage election(s) and increase his or her Compensation Reduction Amount under the Plan to pay any additional costs for coverage for the child. If a judgment, decree or order requires an Eligible Employee's former spouse to provide coverage for a child that the Eligible Employee currently covers under the Participating Program(s), and the former spouse provides this coverage, the Eligible Employee may change his coverage election(s) and decrease his or her Compensation Reduction Amount under the Plan to reflect any reduction in costs for coverage for the child.

(E) Changes in Cost or Coverage. An Eligible Employee who experiences a Change in Cost or Coverage as described below related to a Participating Program other than the Health Care Flexible Spending Account Program may change his or her election(s) as follows:

- (1) Insignificant Change in Cost. If the cost of coverage under a Participating Program increases (or decreases) insignificantly (as determined by the Plan Administrator) during a Plan Year, the Plan Administrator may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in the affected Eligible Employees'

Compensation Reduction Amount under the Plan to reflect such cost of coverage change.

- (2) Significant Increase in Cost. If the cost of coverage under the Participating Program increases significantly, as determined by the Plan Administrator, an Eligible Employee may (a) increase his or her Compensation Reduction Amount under the Plan to reflect that increase, or (b) reduce his or her Compensation Reduction Amount under the Plan to reflect a cancellation of coverage if permitted by the Participating Program, and in lieu thereof, either receive on a prospective basis coverage under another benefit package option providing similar coverage or drop coverage if no other benefit package option providing similar coverage is available.
- (3) Significant Decrease in Cost. If the cost of coverage under the Participating Program decreases significantly, as determined by the Plan Administrator: (a) an Eligible Employee may change his or her coverage election(s) and Compensation Reduction Amount to reflect the added cost of the coverage for the previously unenrolled Dependent if permitted by the Participating Program; and (b) a non-participating Eligible Employee may change his or her coverage election(s) and Compensation Reduction Amount to reflect the added cost of coverage for the Eligible Employee and Dependent (if any) if permitted by the Participating Program.
- (4) Change in Coverage – Curtailment. If the coverage under the Participating Program is curtailed significantly, as determined by the Plan Administrator, an affected Eligible Employee may change his or her coverage election(s) and Compensation Reduction Amount to reflect the election of a similar coverage option to the extent permitted by the Participating Program. If coverage under the Participating Program is so significantly curtailed as to constitute a loss of coverage, as determined by the Plan Administrator, an affected Eligible Employee may change his or her coverage election(s) and Compensation Reduction Amount to reflect (as permitted by the Participating Program)

the election of a similar coverage option, or, if there is no similar coverage option, the revocation of coverage under a Participating Program.

- (5) Change in Coverage – Improvement. If coverage under the Participating Program is improved significantly, as determined by the Plan Administrator, or a new coverage option becomes available under the Participating Program, an Eligible Employee may change his or her coverage election(s) and Compensation Reduction Amount to reflect the election of a new coverage option (and a related cancellation of a prior coverage option) or the addition of a Dependent, both to the extent permitted by the Participating Program. A non-participating Eligible Employee may change his or her coverage election(s) and Compensation Reduction Amount under the Plan to reflect the election (for the Employee and his or her Dependents) of a new coverage option or the election of coverage under the improved option, both to the extent permitted by the Participating Program.
- (6) Change in Coverage under another Employer Plan. An Eligible Employee can change his or her coverage election(s) and Compensation Reduction Amount if such change is both the result of, and corresponds with, an election change made under another employer plan, if (a) the other employer plan permits participants to make the relevant election change during the plan year, or (b) the other employer plan uses a different period of coverage than the period used by the Plan.
- (7) Loss of Coverage under other Group Health Coverage. An Eligible Employee can change his or her coverage election(s) and Compensation Reduction Amount to add coverage for himself or his Dependent under a Pre-Tax Component Program that is a health plan if such change is both the result of, and corresponds with, a loss of coverage under any group health coverage sponsored by a governmental or educational institution.

(F) Paid Leave of Absence. An Eligible Employee who takes or returns from a paid leave of absence from his or her employment with the Employee may change his or her coverage election(s) and Compensation Reduction Amount under the Plan to correspond with taking or returning from such leave of absence.

(ii) With respect to the LTD, Life, Accident, LTC and Legal Assistance Participating Programs and the Dependent Day Care Flexible Spending Account Program, except as otherwise provided by the Program Document for such Participating Program, an Eligible Employee who experiences a Change in Status that makes him (or a Spouse or Child, if applicable) eligible or ineligible for coverage under a Participating Program may change his or her coverage election(s) and Compensation Reduction Amount under the Plan to correspond with such Change in Status.

(iii) With respect to the Legal Assistance Participating Programs and the Dependent Day Care Flexible Spending Account Program, except as otherwise provided by the Program Document for such Participating Program, an Eligible Employee who takes or returns from a paid leave of absence from his or her employment with the Employer may change his or her coverage election(s) and Compensation Reduction Amount under the Plan to correspond with such Change in Status.

(b) Modification and Revocation Procedure. An election or waiver may be modified or revoked due to a change under this Section 5.4 only if such modification or revocation is made in writing on a new enrollment form, or through any other means designated by the Plan Administrator, and within the time limits designated by the Plan Administrator. However, election changes under this Section 5.4 shall be made not later than thirty-one (31) days after the date the Qualified Life Event occurs; provided that, in the case of a Qualified Life Event described in Code Section 9801(f)(3)(A), an election change must be made within sixty (60) days of such Qualified Life Event.

(c) Effective Date of Election Changes. Any coverage election changes permitted under this Section 5.4 shall take effect as of the date the Qualified Life Event occurs. However, any corresponding change in an Eligible Employee's Compensation Reduction Amount for such coverage election shall take effect as of the paycheck date next following the date that the Participant completes and returns the new enrollment form (or such other means designated by the Plan Administrator).

5.5 Adjustment of Election or Account.

(a) The Plan Administrator has the right to direct the Company to adjust any Participant's Compensation Reduction Amount under the Plan at any time and from time to time, as well as to adjust any Participant's Account, to ensure that the Plan complies with any applicable nondiscrimination requirements of Sections 105, 125, and 129 of the Code and to rectify erroneous Compensation reductions and credits not otherwise

corrected under Sections 6.1, 8.1, or 9.1. The Plan Administrator may periodically conduct nondiscrimination testing, as it deems necessary.

(b) The Plan shall not provide any qualified benefits as defined in Section 125(f) of the Code in a Plan Year to key employees as defined in Section 416(i)(1) of the Code in excess of 25 percent of the aggregate of benefits provided to all Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits that (without regard to this paragraph) are includible in gross income.

5.6 Maximum Payroll Reduction Election. No Participant shall be permitted to elect a Compensation Reduction Amount under the Plan for any Plan Year in excess of the maximum aggregate cost to any Employee of the broadest coverage available for such Plan Year with respect to the Flexible Benefit Options. The maximum cost for Pre-Tax Component Program coverage provided by the Plan shall be determined from time to time by the Plan Administrator. The maximum amount a Participant may contribute to either his or her Health Care Flexible Spending Account, Limited Purpose Flexible Spending Account or Dependent Day Care Flexible Spending Account shall be determined in accordance with Article VI, Section 7.7, Article VIII, the terms of the applicable Program Document and applicable law.

5.7 Changes by Plan Administrator. If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any requirement or limitation imposed by the Code, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include a modification of Participant elections, with or without the consent of such Participants.

5.8 Maintenance of Accounts.

(a) The Plan Administrator or its delegate shall maintain an Account for each Flexible Benefit Option elected by each Participant for the Plan Year. The Accounts shall be credited periodically with such Compensation Reduction Amounts as the Participant has designated for allocation toward such Flexible Benefit Options for the pay periods since the last such credit was made. The Accounts shall not be funded and shall not earn or accrue any interest for the benefit of any Participant.

(b) Claims for reimbursement shall be made in such form and accompanied by such substantiation, as the Plan Administrator shall require. The Plan Administrator shall deduct from the applicable Account the amount necessary to pay the Participant's share of costs or Required Contributions for the applicable Flexible Benefit Option. Total deductions from any Account for a Plan Year shall not exceed the total amount designated by the Participant to be credited to the Account for such Plan Year.

(c) Whenever a Participant is, in the Plan Administrator's opinion, under a legal disability or incapacitated in any way so as to be unable to manage his or her personal financial affairs, the Plan Administrator may direct the Flexible Benefit Option payment to which such Participant is then entitled to be made to the Participant's legal representative, or to a friend or relative of the Participant, or in such other manner

(including direct deposit to a bank account in the name of the Participant) as the Plan Administrator considers appropriate for the benefit of such Participant. Any such payment shall constitute a complete discharge of any liability of the Plan and the Participating Employers with respect to, and to the extent of, the Flexible Benefit Option payment so made.

5.9 Rights of Participants. No Participant shall have any right to any amount credited to his or her Account at any time, except the right to have such credits applied toward his or her Flexible Benefit Options in accordance with the Plan, and the right to have any excess amounts that were deducted from his or her Compensation and credited to his or her Account by mistake of the Plan Administrator restored to him or her as though part of his or her Compensation. Such restoration shall be made only if the Participant so requests in writing, the written request is received by the Plan Administrator within one year after the mistaken credit was made, and the mistaken amount has not already been applied toward the Participant's designated Flexible Benefit Options. If such restoration cannot be made solely because the mistaken amount has already been applied toward the Participant's designated Flexible Benefit Options, then the Plan Administrator may direct the Company to adjust the Participant's future Compensation reductions under the Plan to rectify the prior mistake. No interest shall accrue or be owed to any Participant with respect to any restoration of Compensation under this Section 5.9.

5.10 Forfeitures. Notwithstanding any provision of the Plan to the contrary, this Section 5.10 shall not apply to Health Savings Accounts under Article VII and HRAs under Article IX.

(a) As of the first day after the final reimbursement date for the Plan Year, as designated by the Plan Administrator, any amounts credited to a Participant's Account that remain after making deductions for such Plan Year shall be forfeited. The Participant's Account balance for each Plan Year shall start at zero. Unused Account balances shall not be carried over from one Plan Year to the next.

(b) If a Participant revokes Flexible Benefit Options under one or more of his or her Accounts due to a Qualified Life Event described in Section 5.4, then he or she shall forfeit any unused amounts remaining credited to such Account after claims and deductions with respect to the period prior to the Qualified Life Event described in Section 5.4, have been satisfied in accordance with the Plan.

(c) The Company shall determine the aggregate forfeitures under the Health Care Flexible Spending Accounts, the Limited Purpose Flexible Spending Accounts and the Dependent Day Care Flexible Spending Accounts for any particular Plan Year and shall apply such forfeitures: (i) insofar as possible, to the reasonable expense of maintaining and administering the Health Care, Limited Purpose and Dependent Day Care Flexible Spending Accounts for the Plan Year in which the forfeiture occurs, or (ii) as otherwise permitted under Section 125 of the Code and regulations issued thereunder.

ARTICLE VI

HEALTH CARE FLEXIBLE SPENDING ACCOUNT PROGRAM

6.1 Generally. The Health Care Flexible Spending Account Program is intended to be a “self-insured medical reimbursement plan” within the meaning of Section 105(h) of the Code and a flexible spending arrangement within the meaning of Treasury Regulation Section 1.125-2. The provisions of this Article VI shall apply to such Health Care Flexible Spending Account Program, in addition to the terms set forth in the applicable Program Document. In the event that there is a conflict between the specific terms of a Program Document and the terms of this Article VI of the Plan, the Plan will control (unless contrary to applicable law). The Plan Administrator will take whatever steps are necessary to maintain and operate the Health Care Flexible Spending Account Program as a “nondiscriminatory” plan within the meaning of Sections 105(h) and 125 of the Code. The other Articles of the Plan shall apply, as needed, to complete the terms of such Health Care Flexible Spending Account Program.

6.2 Election Procedure. An Eligible Employee may elect to participate in a Health Care Flexible Spending Account Program by filing an election and Compensation reduction agreement in accordance with the procedures established under the applicable Program Document. Such an election to participate shall be irrevocable during the Plan Year, subject to the following special circumstances that may permit a modification or revocation of the Participant’s elections: (a) the Participant’s termination of employment with the Participating Employers, (b) the Participant ceases to be an Eligible Employee, (c) the Participant’s earnings are reduced to an amount less than the Participant’s election, (d) the application of the nondiscrimination requirements of the Code, or (e) as provided under Section 5.4(a)(i) of the Plan. Participants who elect to participate in a Health Savings Account for a Plan Year shall not be eligible to participate in the Health Care Flexible Spending Account Program for such Plan Year.

6.3 Cessation of Participation. A Participant will cease to be a Participant in a Health Care Flexible Spending Account Program as of the earliest to occur of the following:

- (a) The end of the calendar year (unless the Participant re-elects to participate for the next Plan Year in accordance with Section 5.1 of the Plan);
- (b) The date the Participant ceases to make the Required Contributions;
- (c) The date the Participant’s Health Care Flexible Spending Account has been distributed entirely;
- (d) The date the Participant terminates employment (unless the Participant elects to continue coverage under COBRA in accordance with Section 6.9);
- (e) The date the Participant ceases to be an Eligible Employee; or
- (f) The date the Plan or the Health Care Flexible Spending Account Program terminates.

6.4 Revocation of Coverage. A Participant who terminates employment with the Participating Employers or is no longer an Eligible Employee shall be deemed to have revoked his or her elections for Flexible Benefit Options, and expenses incurred after the date of such employment termination or loss or eligibility shall not be reimbursed from the Participant's Health Care Flexible Spending Account. Such Participant will continue to be eligible to claim reimbursement for expenses incurred through the date on which he or she terminates employment or loses eligibility, but such claims must be submitted within the time limits specified in the applicable Program Document in order to be eligible for reimbursement under the Program. Notwithstanding anything contained in the Plan to the contrary, to the extent COBRA applies to the continuation of coverage rights of a Participant under the Health Care Flexible Spending Account Program, such Participant shall be permitted to make Required Contributions to his or her Health Care Flexible Spending Account on an after-tax basis only, in accordance with Section 6.9. In the event of the Participant's death, the Participant's Spouse (or, if none, the Participant's executor or Plan Administrator) may apply on the Participant's behalf for reimbursements permitted under this Section 6.4.

6.5 Minimum and Maximum Contribution. Each Eligible Employee may elect to have the Compensation otherwise payable to him or her for each payroll period during the Plan Year reduced, so that the Participating Employer shall make contributions in the form of credits to the Participant's Health Care Flexible Spending Account equal to the amount by which the Employee elects to have his or her Compensation reduced. The minimum and maximum Employee contributions allowed to be allocated and credited to a Participant's Health Care Flexible Spending Account per Plan Year for eligible health care expenses shall be limited as set forth in the applicable Program Document, provided that total reduction in Compensation for any Participant in a Plan Year shall not exceed the amount of his or her Compensation or the maximum amount prescribed by applicable law. In the event that an Employee elects to enroll in the Health Care Flexible Spending Account mid-Plan Year or to change his or her election under the Health Care Flexible Spending Account mid-Plan Year (in accordance with Section 5.4), the minimum and maximum contribution amounts will be prorated for time remaining in the Plan Year.

6.6 Reimbursable Expenses.

(a) A Participant shall be entitled to reimbursement for eligible health care expenses that he or she incurs during the Plan Year for his or her own health care and the health care of his or her eligible Dependents. The maximum benefits payable to any Participant under the Health Care Flexible Spending Account Program for any Plan Year shall not exceed the lesser of:

(i) the total contributions designated by the Participant as allocable to the Health Care Flexible Spending Account for the Plan Year; and

(ii) the eligible health care expense claims made on the Health Care Flexible Spending Account for the Plan Year.

Benefits up to this maximum shall be payable for eligible health care expense claims, without regard to the Participant's Health Care Flexible Spending Account balance at

such time, even if the claim exceeds the amount credited to that date under such Account and thereby causes a negative balance in the Participant's Health Care Flexible Spending Account.

(b) Subject to any limitations or exclusions under the Program Document, eligible health care expenses under the Health Care Flexible Spending Account Program are expenses for "medical care" as defined in Sections 213(d)(1)(A) and (B) of the Code (regardless of any dollar limits on deductions under that statute) for the treatment of the Participant or his or her "eligible dependents" as defined in the underlying Program Document, but which expenses are not reimbursed from any other source; provided, however, that expenses for the following are excluded: (i) long-term care services under Section 213(d)(1)(C) of the Code, (ii) insurance under Section 213(d)(1)(D) of the Code, and (iii) medicines and drugs that are available without a prescription (i.e., over-the-counter), unless such medicine or drug is insulin, or is prescribed by a health care professional who is legally authorized to issue the prescription.

6.7 Claim and Payment Procedures. Claims for reimbursement shall be made on the appropriate form or forms furnished by the Plan Administrator for purposes of the Program and shall be submitted to the Plan Administrator in accordance with the time limits and additional requirements specified in the applicable Program Document. Claims for expenses incurred during a Plan Year that are received by the Plan Administrator after the date specified in the applicable Program Document will be considered untimely and not eligible for reimbursement. In order to be reimbursed for an eligible expense, the Participant shall furnish any additional information or documentation, such as receipts, insurance company explanations of benefits, and statements from the health care service provider that is required by the Plan Administrator or the Code and any guidance issued thereunder to substantiate such claim. Reimbursement from the Participant's Health Care Flexible Spending Account shall be payable to the Participant in the time and manner set forth in the Program Document or required by applicable law. The appeal of claims that are denied under this Section 6.7 are governed by Article XI and the applicable Program Document.

6.8 Credit Balance at End of Plan Year. A Participant or former Participant shall not be entitled to receive cash or any other form of compensation or benefits with respect to any unused credit balance in his or her Health Care Flexible Spending Account after all timely claims have been processed as of the end of a Plan Year.

6.9 COBRA Continuation Coverage. COBRA continuation coverage will be provided under the Health Care Flexible Spending Account Program as described in the applicable Program Document. However, notwithstanding anything in this Section 6.9 or the underlying Program Document to the contrary, COBRA continuation coverage will not be provided under the Program for the Plan Year in which the qualifying event occurs, if as of the date of the qualifying event, the Participant or covered Dependent cannot become entitled to receive during the remainder of such Plan Year a benefit under the Health Care Flexible Spending Account Program that exceeds the maximum amount that the Participant or covered Dependent must pay for COBRA for the remainder of such Plan Year. For purposes of this determination of the amount of the benefit under the Program that the Participant or covered Dependent can become entitled to receive during the remainder of the Plan Year in which the

qualifying event occurs, the Program may deduct from the maximum benefit available to the Participant any reimbursable claims submitted to the Program before the date the qualifying event occurred. This Section 6.9 is intended and shall be construed to satisfy the minimum requirements of COBRA, but not to create any rights in excess of such minimum requirements. The Plan Administrator shall adopt such rules for the administration of this Section 6.9 as it shall deem necessary and appropriate from time to time.

ARTICLE VII

HEALTH SAVINGS ACCOUNT TERMS

7.1 Health Savings Account. One or more Medical Participating Program coverage options may include a Health Savings Account.

7.2 Health Savings Account Contributions.

(a) Employee Contributions. A HSA-Eligible Individual may elect to have a portion of his or her Compensation forwarded on a pre-tax basis or may contribute on an after-tax basis to a Health Savings Account established with one or more designated trustee(s) or custodian(s) (an “eligible HSA”), provided that the HSA-Eligible Individual has established his or her Health Savings Account as determined by the Plan Administrator. The Company reserves the right to select in its discretion the designated trustee(s) or custodian(s) to which it shall forward HSA Contributions. If a Participant elects to make pre-tax contributions to an eligible HSA, the Eligible Employee’s Compensation will be reduced, and an amount equal to the reduction will be forwarded to the Eligible Employee’s Health Savings Account. During the Plan Year, such election can be increased, decreased or revoked prospectively, effective as of the first day of the month following the date the Participant elects to change his or her HSA Contribution amount.

(b) Employer Contributions. The Company may in its discretion contribute an amount to a Health Savings Account on behalf of an HSA-Eligible Individual who has established his or her Health Savings Account as determined by the Plan Administrator through the Plan, without regard to the comparability rules of Section 4980G of the Code. The Company reserves the right to change the amount or timing of such contributions at any time, and from time to time.

7.3 Maximum HSA Contribution Limits. An HSA-Eligible Individual’s contributions, combined with the Company’s contribution, if any, made to the HSA-Eligible Individual’s Health Savings Account under Section 7.2 are subject to the statutory maximum amount under Section 223(b) of the Code for the calendar year in which the contribution is made. Each HSA-Eligible Individual shall ensure that he or she does not elect contributions as described in Section 7.2 to the extent that the statutory maximum amount under Section 223(b) of the Code would be exceeded in a Plan Year.

7.4 Recording Contributions. As described in Section 7.6, the Health Savings Account coverage described herein is not an employer-sponsored employee benefit plan – it is an

individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the Health Savings Account trustee/custodian, not the Company, will establish and maintain the Health Savings Account. The Company may, however, limit the number of Health Savings Account providers to whom it will forward contributions that the Eligible Employee makes on a pre-tax basis. The Plan Administrator will maintain records to keep track of HSA Contributions an Eligible Employee makes on a pre-tax basis, but it will not require a separate fund or otherwise segregate assets for this purpose.

7.5 Tax Treatment of HSA Contributions and Distributions. The tax treatment of the Health Savings Account (including contributions and distributions) is governed by Section 223 of the Code and any applicable state law.

7.6 Trust/Custodial Agreement; HSA Not Intended to Be an ERISA Plan.

(a) HSA Contributions under this Plan consist solely of the Participant's contributions to the Health Savings Account on a pre-tax or after-tax basis and any discretionary employer contributions. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, investments, payment debit/credit cards, etc.) for each Participant's HSA trust or custodial account will be provided by and are set forth in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan.

(b) The Health Savings Account is not an employer-sponsored employee benefit plan. It is a savings account that is established and maintained by a HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Section 223(d)(2) of the Code. The Company has no authority or control over an HSA-Eligible Individual's use of the funds that have been deposited in a Health Savings Account. The Health Savings Account feature of this Plan under this Article VII is not subject to the continuation coverage requirements under COBRA. Even though this Plan may allow pre-tax Employee contributions to a Health Savings Account, the HSA is not intended to be an ERISA-governed benefit plan sponsored or maintained by the Company. Distributions from a Participant's Health Savings Account (whether before or after termination of employment) and all other matters relating to a Participant's HSA are outside of this Plan.

7.7 Limited Purpose Flexible Spending Account Program. Participants who elect a Medical Participating Program coverage option that includes a Health Savings Account under this Article VII may also elect to participate in a Limited Purpose Flexible Spending Account. The Limited Purpose Flexible Spending Account is a specific type of Account under the Health Care Flexible Spending Account Program and is intended to be a "self-insured medical reimbursement plan" within the meaning of Section 105(h) of the Code, a flexible spending arrangement within the meaning of Treasury Regulation Section 1.125-5 and a combination of a limited-purpose health flexible spending arrangement and a post-deductible health flexible spending arrangement that is a HSA-compatible health flexible spending arrangement within the meaning of Treasury Regulation Section 1.125-5(m). The provisions of this Section 7.7 shall apply to the Limited Purpose Flexible Spending Account, in addition to the terms set forth in the applicable Program Document. In the event that there is a conflict between the specific terms of

a Program Document and the terms of this Section 7.7 of the Plan, the Plan will control (unless contrary to applicable law). The Plan Administrator will take whatever steps are necessary to maintain and operate the Limited Purpose Flexible Spending Account Program as a 'nondiscriminatory' plan within the meaning of Sections 105(h) and 125 of the Code. The other provisions of the Plan shall apply, as needed, to complete the terms of such Limited Purpose Flexible Spending Account Program.

(a) Election Procedure. An Eligible Employee may elect to participate in a Limited Purpose Flexible Spending Account by filing an election and Compensation reduction agreement in accordance with the procedures established under the applicable Program Document. Such an election to participate shall be irrevocable during the Plan Year, subject to the following special circumstances that may permit a modification or revocation of the Participant's elections: (a) the Participant's termination of employment with the Participating Employers, (b) the Participant ceases to be an Eligible Employee, (c) the Participant ceases to participate in a Medical Participating Program coverage option that includes a Health Savings Account, (d) the Participant's earnings are reduced to an amount less than the Participant's election, (e) the application of the nondiscrimination requirements of the Code, or (f) as provided under Section 5.4(a)(i) of the Plan.

(b) Cessation of Participation. A Participant will cease to be a Participant in a Limited Purpose Flexible Spending Account Program as of the earliest to occur of the following:

(i) The end of the calendar year (unless the Participant re-elects to participate for the next Plan Year in accordance with Section 5.1 and Article VII of the Plan);

(ii) The date the Participant ceases to make the Required Contributions;

(iii) The date the Participant's Limited Purpose Flexible Spending Account has been distributed entirely;

(iv) The date the Participant terminates employment (unless the Participant elects to continue coverage under COBRA in accordance with Section 6.9);

(v) The date the Participant ceases to be an Eligible Employee or ceases to participate in a Medical Participating Program coverage option that includes a Health Savings Account in accordance with Article VII; or

(vi) The date the Plan, the Health Care Flexible Spending Account Program or the Limited Purpose Flexible Spending Account terminates.

(c) Revocation of Coverage. A Participant who terminates employment with the Participating Employers, is no longer an Eligible Employee or no longer participates in a Medical Participating Program coverage option that includes a Health Savings

Account shall be deemed to have revoked his or her elections for the Limited Purpose Flexible Spending Account, and expenses incurred after the date of such employment termination, loss or eligibility or failure to participate shall not be reimbursed from the Participant's Limited Purpose Flexible Spending Account. Such Participant will continue to be eligible to claim reimbursement for expenses incurred through such date, provided these claims are submitted within the time limits specified in the applicable Program Document in order to be eligible for reimbursement under the Program. Notwithstanding anything contained in the Plan to the contrary, to the extent COBRA applies to the continuation of coverage rights of a Participant under the Health Care Flexible Spending Account Program, such Participant shall be permitted to make Required Contributions to his or her Limited Purpose Flexible Spending Account on an after-tax basis only, in accordance with Section 6.9. In the event of the Participant's death, the Participant's Spouse (or, if none, the Participant's executor or Plan Administrator) may apply on the Participant's behalf for reimbursements permitted under this Section 7.7.

(d) Minimum and Maximum Contribution. Each Eligible Employee may elect to have the Compensation otherwise payable to him or her for each payroll period during the Plan Year reduced, so that the Participating Employer shall make contributions in the form of credits to the Participant's Limited Purpose Flexible Spending Account equal to the amount by which the Employee elects to have his or her Compensation reduced. The minimum and maximum Employee contributions allowed to be allocated and credited to a Participant's Limited Purpose Flexible Spending Account per Plan Year for eligible expenses shall be limited as set forth in the applicable Program Document, provided that total reduction in Compensation for any Participant in a Plan Year shall not exceed the amount of his or her Compensation or the maximum amount prescribed by applicable law.

(e) Reimbursable Expenses.

(i) A Participant shall be entitled to reimbursement for eligible expenses that he or she incurs during the Plan Year for his or her own health care and the health care of his or her eligible Dependents. The maximum benefits payable to any Participant under the Limited Purpose Flexible Spending Account for any Plan Year shall not exceed the lesser of: (A) the total contributions designated by the Participant as allocable to the Limited Purpose Flexible Spending Account for the Plan Year; and (B) the eligible expense claims made on the Limiting Flexible Spending Account for the Plan Year. Benefits up to this maximum shall be payable for eligible expense claims, without regard to the Participant's Limited Purpose Flexible Spending Account balance at such time, even if the claim exceeds the amount credited to that date under such Account and thereby causes a negative balance in the Participant's Limited Purpose Flexible Spending Account.

(ii) Subject to any limitations or exclusions under the Program Document, eligible expenses under the Limited Purpose Flexible Spending Account Program are expenses for the treatment of the Participant or his or her 'eligible dependents' as defined in the underlying Program Document that are (A)

vision care and dental care expenses that constitute 'permitted coverage' under Section 223(c)(1)(B), (B) preventive care expenses under Section 223(c)(2)(C) of the Code, or (C) medical care expenses (as defined in Section 213(d) of the Code) incurred after the minimum annual deductible under Section 223(c)(2)(A)(i) is satisfied. Notwithstanding the foregoing, expenses for the following are excluded and are not eligible for reimbursement under the Limited Purpose Flexible Spending Account Program: expenses that are reimbursed from any other source, long-term care services under Section 213(d)(1)(C) of the Code, insurance under Section 213(d)(1)(D) of the Code, and medicines and drugs that are available without a prescription (i.e., over-the-counter), unless such medicine or drug is insulin or is prescribed by a health care professional who is legally authorized to issue the prescription. No medical expenses incurred before the annual deductible under the Medical Participating Program coverage option is satisfied may be reimbursed under the Limited Purpose Flexible Spending Account, regardless of whether the coverage option covers the expense or whether the deductible is later satisfied. The deductible that is applicable under this subsection (e) shall be the annual deductible designated for such Plan Year in the applicable Program Document, provided that such annual deductible is not less than the annual deductible set forth for such Plan Year under Section 223(c)(2)(A)(i) of the Code. Until the annual deductible for such Plan Year is satisfied, only eligible expenses that are vision care and dental care expenses that constitute "permitted coverage" under Section 223(c)(1)(B) or preventive care expenses under Section 223(c)(2)(C) of the Code may be reimbursed from the Limited Purpose Flexible Spending Account.

(f) Claim and Payment Procedures. Claims for reimbursement under the Limited Purpose Flexible Spending Account shall be made on the appropriate form or forms furnished by the Plan Administrator for purposes of the Health Care Flexible Spending Account Program and shall be submitted to the Plan Administrator in accordance with the time limits and additional requirements specified in the applicable Program Document. Claims for expenses incurred during a Plan Year that are received by the Plan Administrator after the date specified in the applicable Program Document will be considered untimely and not eligible for reimbursement. In order to be reimbursed for an eligible expense, the Participant shall furnish any additional information or documentation, such as receipts, insurance company explanations of benefits, and statements from the health care service provider that is required by the Plan Administrator or the Code and any guidance issued thereunder to substantiate such claim. Reimbursement from the Participant's Limited Purpose Flexible Spending Account shall be payable to the Participant in the time and manner set forth in the Program Document or required by applicable law. The appeal of claims that are denied under this subsection (f) are governed by Article XI and the applicable Program Document.

(g) Credit Balance at End of Plan Year. A Participant or former Participant shall not be entitled to receive cash or any other form of compensation or benefits with respect to any unused credit balance in his or her Limited Purpose Flexible Spending Account after all timely claims have been processed as of the end of the claims

processing period related to the corresponding Plan Year. Such unused credit balance, if any, shall be forfeited as provided by Section 5.10.

(h) COBRA Continuation Coverage. COBRA continuation coverage will be provided under the Limited Purpose Flexible Spending Account Program as described in Section 6.9 of the Plan and the applicable Program Document.

ARTICLE VIII

DEPENDENT DAY CARE FLEXIBLE SPENDING ACCOUNT PROGRAM

8.1 Generally. The Dependent Day Care Flexible Spending Account Program is intended to be a “dependent care assistance program” within the meaning of Section 129 of the Code and a flexible spending arrangement within the meaning of Regulation Section 1.125-2. The provisions of this Article VIII shall apply to such Dependent Day Care Flexible Spending Account Program in addition to the terms set forth in the applicable Program Document. In the event that there is a conflict between the specific terms of a Program Document and the terms of this Article VIII of the Plan, the Plan will control (unless contrary to applicable law). The Company and the Plan Administrator will take whatever steps are necessary to maintain and operate the Dependent Day Care Flexible Spending Account Program as a “nondiscriminatory” plan within the meaning of Sections 129 and 125 of the Code. The other Articles of the Plan document shall apply, as needed, to complete the terms of the Dependent Day Care Flexible Spending Account Program.

8.2 Election Procedure. A Participant may elect to participate in the Dependent Day Care Flexible Spending Account Program by filing an election and Compensation reduction agreement in accordance with the procedure established under the applicable Program Document. Such an election to participate shall be irrevocable during the Plan Year, subject to the special rules that may permit modification or revocation of elections outside of the annual enrollment period, as provided in Section 5.4 of the Plan.

8.3 Cessation of Participation. A Participant will cease to be a Participant in the Dependent Day Care Flexible Spending Account Program as of the earliest to occur of the following:

- (a) The end of the calendar year (unless the Participant re-elects to participate for the next Plan Year in accordance with Section 5.1 of the Plan);
- (b) The date the Participant ceases to make the Required Contributions;
- (c) The date the Participant’s Dependent Day Care Flexible Spending Account has been distributed entirely;
- (d) The date the Participant terminates employment;
- (e) The date the Participant ceases to be an Eligible Employee;

(f) The date the Plan is amended to eliminate coverage under the Dependent Day Care Flexible Spending Account Program; or

(g) The date the Plan or the Dependent Day Care Flexible Spending Account Program terminates.

8.4 Revocation of Coverage. In the event a Participant terminates employment with the Participating Employers or is no longer an Eligible Employee, the Participant's Compensation reduction agreement relating to dependent care assistance shall terminate, and expenses incurred after the date of such employment termination shall not be reimbursed from the Participant's Dependent Day Care Flexible Spending Account. Such Participant will continue to be eligible to claim reimbursement for expenses incurred through the date on which he or she terminates employment or loses eligibility, but such claims must be submitted within the time limits specified in the applicable Program Document in order to be eligible for reimbursement under the Program. In no event, however, shall a reimbursement exceed the remaining balance, if any, in the Participant's Dependent Day Care Flexible Spending Account for the Plan Year in which the expenses were incurred. In the event of the Participant's death, the Participant's Spouse (or, if none, the Participant's executor or Plan Administrator) may apply on the Participant's behalf for reimbursements permitted under this Section 8.4.

8.5 Minimum and Maximum Contribution. Each Eligible Employee may elect to have the Compensation otherwise payable to him or her for each payroll period during the Plan Year reduced, so that the Company shall make contributions in the form of credits to the Participant's Dependent Day Care Flexible Spending Account equal to the amount by which the Employee elects to have his or her Compensation reduced. The minimum and maximum Employee contributions allowed to be allocated and credited to a Participant's Dependent Day Care Flexible Spending Account per Plan Year for eligible dependent care expenses shall be limited as set forth in the applicable Program Document, provided that total reduction in Compensation for any Participant in a Plan Year shall not exceed the amount of his or her Compensation and shall not exceed \$5,000 (\$2,500 for a married taxpayer filing as a single individual) per Plan Year.

8.6 Dependent Care Expense Benefits. Each Participant shall be entitled to reimbursement for those dependent care expenses incurred during a Plan Year that (a) are considered eligible employment-related expenses under the child and dependent care credit provisions of Section 21(b)(2) of the Code (and regulations thereunder), and (b) do not exceed the earned income limitations specified below, but only to the extent of the credit balance in the Participant's Dependent Day Care Flexible Spending Account at the relevant time. Dependent care expenses shall be deemed to be incurred at the time the services to which the expenses related are rendered. The Participant may not assign the right to receive benefit payments from the Dependent Day Care Flexible Spending Account for dependent care expenses. The rules set forth in the underlying Program Document, along with any other applicable rules of Sections 21(b) and 129 of the Code, apply in determining whether the expenses of the Participant are for reimbursable dependent care expenses under the Plan.

8.7 Earned Income Limitation. For any Plan Year, the payments made to any Participant under a Dependent Day Care Flexible Spending Account Program shall not exceed the earned income limitation determined under the following rules:

(a) In the case of a Participant who is not married at the close of the Plan Year, this limitation is the earned income of the Participant. "Earned income" means the total wages, salary, and other employee compensation and any net earnings from self-employment (determined with regard to the deduction allowed under Code Section 164(f)) for the Plan Year.

(b) In the case of a Participant who is married at the close of the Plan Year, this limitation is the lesser of the earned income of the Participant or the earned income of the Participant's Spouse.

(c) During any month in the Plan Year, if the Participant's Spouse is either a full-time student at an educational institution, or physically or mentally unable to take care of himself, the Spouse shall be deemed to have "earned income" for each month of \$250 (or \$500 if there are at least two qualifying individuals with respect to the Participant).

(d) Married Participants who are legally separated or living apart will be considered not married if they are treated as not married under the rules of Section 21(e)(3) and (4) of the Code.

8.8 Nondiscrimination Rules. The Dependent Day Care Flexible Spending Account Program shall comply with all nondiscrimination requirements set forth in Section 129 of the Code and any guidance issued thereunder as necessary to qualify as a "dependent care assistance program" under Section 129 of the Code.

8.9 Claim and Payment Procedures.

(a) Claims for reimbursement shall be made on the appropriate form(s) furnished by the Plan Administrator for purposes of the Plan and shall be submitted to the Plan Administrator in accordance with the time limits specified in the applicable Program Document. The Participant will be required to furnish receipts and statements from the providers of dependent care and certify that the information is true.

(b) All claims submitted by a Participant during a reimbursement period shall be processed as of the end of that reimbursement period on the basis of the balance in the Participant's Dependent Day Care Flexible Spending Account at the end of such reimbursement period. To the extent that any claims cannot be paid in full because of an insufficiency in the Participant's Dependent Day Care Flexible Spending Account, the claims shall be held for payment in the next succeeding reimbursement period(s) of the same Plan Year, but shall not be carried over or charged against the balance of any subsequent Plan Year.

(c) Benefits shall be payable as soon as administratively possible, as set forth in the Program Document. The appeal of claims that are denied under this Section 8.9

are governed by the applicable provisions of Article XI and the applicable Program Document.

8.10 Credit Balance at End of Plan Year. Claims for expenses incurred during a Plan Year that are received by the Plan Administrator after the date specified in the applicable Program Document will be considered untimely and not eligible for reimbursement under the Program. A Participant or former Participant shall not be entitled to receive cash or any other form of compensation or benefits with respect to any unused credit balance in his or her Dependent Day Care Flexible Spending Account after all timely claims have been processed as of the end of a Plan Year. Similarly, no credit balance remaining after the expiration of the period for submitting claims for one Plan Year will be carried forward into any succeeding Plan Year. Such unused credit balance, if any, shall be forfeited or otherwise applied as provided by Section 5.10.

ARTICLE IX

HEALTH REIMBURSEMENT ARRANGEMENT PLAN TERMS

9.1 Health Reimbursement Accounts. One or more Medical Participating Program coverage options may include a HRA. The Plan Administrator will take whatever steps are necessary to maintain and operate the HRA program as a “nondiscriminatory” plan within the meaning of Section 105(h) of the Code.

9.2 Participation. Subject to the eligibility requirements set forth in the applicable Medical Participating Program coverage option, Eligible Employees may be eligible to participate in a HRA to receive reimbursements for their eligible medical expenses. The Plan Administrator shall establish guidelines to identify the extent to which Participants are permitted to participate in a HRA under the Plan, based on such factors as, but not limited to, the option under the Medical Participating Program in which the Participant enrolls. If a Participant does not elect the coverage option under the Medical Participating Program that includes a HRA, such Participant shall be deemed to have waived his or her participation in the HRA.

9.3 Termination of HRA. A Participant who terminates employment, is no longer an Eligible Employee or elects not to participate in a Medical Participating Program that provides for a HRA shall be eligible to claim reimbursement only with respect to eligible medical expenses incurred prior to the effective date of such termination of employment, ineligibility or coverage election, except to the extent of any COBRA continuation coverage or in certain instances upon the Eligible Employee’s retirement from a Participating Employer. After a Participant terminates employment, is no longer an Eligible Employee, or elects not to participate in a Medical Participating Program that provides for a HRA, such Participant will continue to be eligible to claim reimbursement for expenses incurred prior to his termination of employment, ineligibility or coverage election to the same extent as other Participants, but he shall not be eligible to claim reimbursement for expenses incurred after his termination of employment, ineligibility or coverage election, and any amount remaining in the Participant’s HRA after such reimbursements are made will be forfeited. Notwithstanding the preceding sentence, (a) if an Eligible Employee retires from employment with a Participating Employer or if an Eligible Employee terminates employment and is rehired by a Participating Employer

within the same Plan Year and (b) elects to participate in a Medical Participating Program under the Discover Financial Services Retiree Welfare Benefit Plan or the Plan (as applicable) that provides for a HRA, any amount in the Eligible Employee's HRA under the Plan at the time of retirement or termination shall be reinstated to his HRA under the applicable Medical Participating Program under the Discover Financial Services Retiree Welfare Benefit Plan or the Plan (as applicable). If a Participant elects to participate in a Medical Participating Program that provides for a Health Savings Account (as described in Article VII), such Participant shall not receive reimbursement from the HRA for any expenses as of the first day of the Plan Year for which the Health Savings Account is established or in effect, and any amount remaining in the Participant's HRA immediately prior to such date shall be forfeited.

9.4 Maximum Contribution. A HRA shall be funded solely by contributions made by the Participating Employer(s). The amount, timing of and conditions related to such contributions will be determined by the Plan Administrator in its sole discretion.

9.5 Reimbursable Expenses. Subject to any limitations or exclusions under the applicable Program Document, amounts credited to a Participant's HRA shall be used to reimburse the Participant for eligible medical care expenses under Code Section 213(d) of the Participant and his or her Dependents in accordance with the procedures established by the Plan Administrator in its sole discretion (and as may be described in the applicable Program Document). To the extent such Dependents for which medical care expenses are incurred do not satisfy the requirements of Section 105(b) of the Code and the regulations or other guidance issued thereunder, the Participant shall incur imputed income equal to the full cost of the coverage for such Dependents. The HRA shall not reimburse a medical care expense that is attributable to a deduction that has been allowed under Code Section 213 for a prior tax year or any expenses for prescription drugs as well as medicines and drugs that are available without a prescription (i.e., over-the-counter). A Participant may be reimbursed only for expenses incurred on or after the date on which the Participant first has a HRA established for his benefit.

9.6 Claim and Payment Procedures. Claims for reimbursement shall be made on the appropriate form or forms furnished by the Plan Administrator or through such other administrative practices as established by the Plan Administrator for purposes of the Plan and shall be submitted to the Plan Administrator. The Participant may be required to furnish additional information, as requested by the Plan Administrator, such as receipts, insurance company explanations of benefits, and statements from the health care service provider, substantiating that the expense was incurred and the date the expense was incurred. Benefits shall be payable (reimbursed to the Participant) as soon as administratively possible.

9.7 Credit Balance at End of Plan Year. A Participant or former Participant shall not be entitled to receive cash or any other form of compensation or benefits with respect to any unused credit balance in his HRA after all timely claims have been processed. However, any credit balance remaining after the expiration of the period for submitting claims (as may be established by the Plan Administrator) will be carried forward into any succeeding Plan Year, except to the extent the Participant's HRA participation terminates.

9.8 Ordering Rules. For expenses that are also eligible for reimbursement under the Health Care Flexible Spending Account Program, amounts credited to a Participant's HRA shall

be used first to reimburse such expenses until the Participant's HRA is exhausted, and thereafter, such expenses may be reimbursed from the Participant's Health Care Flexible Spending Account Program, unless the Participant elects otherwise in accordance with the procedures established by the Plan Administrator.

9.9 COBRA Continuation Coverage. COBRA continuation coverage will be provided under the HRAs described in this Section 9.9.

(a) The maximum reimbursement amount at the time of the qualifying event shall be available to a Participant and that maximum amount shall be increased at the same time and by the same increment that it is increased for a similarly situated non-COBRA beneficiary.

(b) This Section 9.9 is intended and shall be construed to satisfy the minimum requirements of COBRA, but not to create any rights in excess of such minimum requirements. The Plan Administrator shall adopt such rules for the administration of this Section 9.9 as it shall deem necessary and appropriate from time to time.

ARTICLE X SPECIAL COVERAGE PROVISIONS

10.1 COBRA Continuation Coverage. All Participating Programs subject to the "continuation coverage" requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended, will be administered in accordance with Code Section 4980B, Part 6 of Subtitle B of Title I of ERISA, any related regulations, and the administrative rules established by the Plan Administrator.

10.2 Family and Medical Leave. All Participating Programs subject to the "maintenance of health benefits" provisions of the FMLA, as amended, will be administered in accordance with the FMLA, any related regulations, and the administrative rules established by the Plan Administrator.

10.3 USERRA. All Participating Programs subject to the "continuation coverage" requirements of USERRA, as amended, will be administered in accordance with USERRA, any related regulations, and the administrative rules established by the Plan Administrator.

10.4 HIPAA. All Participating Programs subject to the "portability" provisions of HIPAA, as amended, will be administered in accordance with HIPAA's provisions, any related regulations, and the administrative rules established by the Plan Administrator.

10.5 Maternity-Related Benefits. All Participating Programs subject to the provisions of the Newborns' and Mothers' Health Protection Act will be administered in accordance with that Act's provisions, any related regulations, and the administrative rules established by the Plan Administrator.

10.6 Mental Health Benefits. All Participating Programs subject to the "parity" requirements of the Mental Health Parity Act and the Mental Health Parity and Addiction Equity

Act of 2008 will be administered in accordance with those Acts' provisions, any related regulations, and the administrative rules established by the Plan Administrator.

10.7 Benefits for Reconstructive Surgery Following a Mastectomy. All Participating Programs subject to the provisions of the Women's Health and Cancer Rights Act under ERISA Section 713 will be administered in accordance with that Act's provisions, any related regulations, and the administrative rules established by the Plan Administrator.

10.8 Use of Genetic Information. All Participating Programs subject to the "health insurance" provisions of the Genetic Information Nondiscrimination Act of 2008 ("GINA") will be administered in accordance with that Act's provisions, any related regulations, and the administrative rules established by the Plan Administrator.

10.9 Health Care Reform. All Participating Programs subject to the "market reform" provisions of PPACA, as amended, will be administered in accordance with PPACA, any related regulations, and the administrative rules established by the Plan Administrator. To the extent and for such period of time that any Participating Program (or any particular plan option under a Participating Program) is considered a "grandfathered health plan" under PPACA, such Participating Program (or plan option) shall be administered in accordance with only the provisions of PPACA and any related regulations to which "grandfathered health plans" are subject.

10.10 Medicaid Eligibility. As required by ERISA Section 609(b), if a Participant is eligible for, or receives, medical assistance under a state plan for medical assistance approved under Title XIX of the federal Social Security Act (Medicaid), any Participating Program subject to ERISA Section 609(b) shall not take such eligibility or provision of benefits into account in enrolling such an individual in any such Participating Program or paying for benefits for such an individual under any such Participating Program. Further, payment for benefits under any Participating Program subject to ERISA Section 609(b) for such individual shall be made in accordance with any assignment of rights made by or on behalf of such an individual as required by a state plan for medical assistance approved under Title XIX of the federal Social Security Act pursuant to Section 1912(a)(1)(A) of the Act (as in effect on August 10, 1993). Finally, to the extent payment has been made under Medicaid for any such individual for benefits payable under any Participating Program subject to ERISA Section 609(b), payment for such benefits under any such Participating Program shall be made in accordance with any state law that provides that the state has acquired the rights with respect to such individual to such payment for such benefits.

10.11 Conversion of Coverage. Unless the Program Documents provide otherwise, the Plan will not provide conversion coverage; provided, however, that nothing in a Participating Program will preclude a Participant from exercising any conversion option made available to him or her by an insurance company under an insurance company contract. Unless the Program Documents provide otherwise, neither the Plan Administrator nor the Company will have any obligation to provide notice of any such conversion option.

10.12 Wellness Programs. Subject to the terms and conditions of the Plan under the Medical Participating Program, Participants may be entitled to benefits with respect to services

or supplies received pursuant to the terms of health promotion and wellness initiatives established and implemented by the Company, such as health risk assessment programs, tobacco surcharge and cessation programs, and certain weight loss programs, with such service providers as the Plan Sponsor deems appropriate (referred to herein as “Wellness Programs”). The Wellness Programs under this Plan are designed to provide Participants with enhanced benefits to aid in the prevention and treatment of health-related problems and to provide “medical care” (as defined in Section 733 of ERISA). Such other wellness or general health promotion programs that the Company may establish for Employees and their dependents that do not provide “medical care” shall not be a part of or subject to the terms of this Plan.

(a) All contracts and other agreements between the Participating Employers and the service providers for any Wellness Program are incorporated as part of the Plan by this reference, except to the extent any contract or agreement with a service provider is inconsistent with the terms of the Plan. The Plan Administrator will provide Participants with descriptions of the Wellness Programs established and implemented under the Plan in separate communication materials from time to time.

(b) The Plan Administrator may, in its sole discretion, terminate or amend any Wellness Program at any time, and the Plan Administrator has the discretion to establish the requirements (including eligibility) of the Wellness Programs and to determine any incentives that may be provided thereunder.

(c) To the extent applicable and required for any particular Wellness Program, such Wellness Program shall be administered in compliance with ERISA, the Code, HIPAA, Title I of GINA, the Americans with Disabilities Act, PPACA and any regulations or guidance issued thereunder with respect to wellness or health promotion programs.

10.13 Certificates of Creditable Coverage.

(a) Automatic. Each HIPAA Program generally will automatically provide a certificate of Creditable Coverage to any Participant (including Dependents, if applicable) after the individual loses coverage under that program. The HIPAA Program will provide such individuals with an automatic certificate of Creditable Coverage within the following time frames:

(i) for an individual who is entitled to elect COBRA continuation coverage, no later than when a notice is required to be provided for a qualifying event;

(ii) for an individual who is not entitled to elect COBRA continuation coverage, within a reasonable time after coverage ceases; and

(iii) for an individual who has elected COBRA continuation coverage, within a reasonable time after cessation of COBRA continuation coverage or, if applicable, after the expiration of any grace period for the payment of contributions.

(iv) A HIPAA Program will not issue an automatic certificate of Creditable Coverage for a Dependent until the HIPAA Program has reason to know that a Dependent has lost coverage under the HIPAA Program.

(b) Upon Request. A certificate of Creditable Coverage will be provided upon request, if the request is made in writing to the Plan Administrator within 24 months after the individual loses coverage under a HIPAA Program. In that case, the certificate of Creditable Coverage will be provided at the earliest time that the HIPAA Program, acting in a reasonable and prompt fashion, can furnish it.

(c) Manner Provided. Each HIPAA Program may provide the certificate of Creditable Coverage in any manner permitted by applicable regulations.

ARTICLE XI

CLAIMS PROCEDURES

11.1 General.

(a) Except to the extent otherwise required by law, all claims for benefits shall be governed by the procedures set forth in the applicable underlying Program Document. To the extent that the Program Document for a particular Participating Program does not provide claims procedures in accordance with Department of Labor Regulation 2560.503-1 and such Regulation applies to the particular Participating Program, the claims procedures for that Participating Program shall be administered to comply with the requirements of such Regulation and any related regulations issued under Section 503 of ERISA. If the Program Document(s) for a particular Participating Program does not provide any claims and appeals procedures, the procedures described in Sections 11.2 through 11.6 shall apply, as applicable according to the type of benefit.

(b) The Plan Administrator has sole discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan shall be paid only if the Plan Administrator decides in its sole discretion that the Claimant is entitled to them. The Plan Administrator may delegate its discretionary authority and responsibilities under this Article to a Claims Administrator and/or Appeals Administrator, provided such delegation is in writing. Any reference to Plan Administrator in this Article shall mean the applicable Claims Administrator or Appeals Administrator if the relevant authority and responsibility has been delegated by the Plan Administrator to that Claims Administrator or Appeals Administrator.

(c) All claims for benefits under the Plan shall be submitted to and decided by the Claims Administrator(s) and Appeals Administrator(s) as the Plan Administrator may from time to time designate, in the form and within the time specified by the Plan Administrator. Decisions made pursuant to this Article XI are intended to be final and binding on Claimants, Participants, beneficiaries and others, as applicable.

11.2 Benefit Claims. Except as provided in the applicable Program Document or to the extent Section 11.5 applies:

(a) Initial Claim Determination. The Claims Administrator shall make initial determinations as to the right of any Claimant to a benefit under the Plan.

(i) Unless an accelerated determination period is required by paragraphs (ii), (iii), (iv) or (v) below, if the Claims Administrator denies in whole or in part any claim for a benefit under the Plan, the Claims Administrator shall furnish the Claimant with written or electronic notice of the Adverse Benefit Determination not later than 90 days after receipt of the claim, unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, the Claimant shall be notified of such extension prior to the termination of the initial 90-day period. In no event shall such extension exceed the period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to issue its determination.

(ii) Notwithstanding the foregoing, with respect to a claim under the Medical, Dental and Vision Participating Programs:

(A) Urgent Care Claims. An “urgent care claim” is a claim for medical care or treatment where the failure to act quickly (1) could seriously jeopardize the Participant’s life or health or ability to regain maximum function or (2) would, in the opinion of a physician with knowledge of the Participant’s medical condition, subject the Participant to severe pain that could not be adequately managed without the requested treatment. If a physician with knowledge of the Participant’s medical condition determines that a claim is an urgent care claim, the claim will be treated as such; otherwise, the Claims Administrator will determine whether a claim is an urgent care claim by applying the judgment of a prudent layperson with an average knowledge of health and medicine. In the case of a claim involving urgent care, the Claims Administrator shall notify the Claimant of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claims Administrator shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Administrator shall notify the Claimant of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of the Claim Administrator’s receipt of the specified information; or the end of the period afforded the Claimant to provide the specified additional information.

(B) Concurrent Care Decisions. If a provider has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

- (1) any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute a denial of the claim. The Claims Administrator shall notify the Claimant of the claim denial at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that denial before the benefit is reduced or terminated; and
- (2) any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Claim Administrator, provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

(C) Pre-Service Claims. In the case of a pre-service claim that does not involve urgent care, the Claims Administrator shall notify the Claimant of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Claims Administrator. This period may be extended one time by the Claims Administrator for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Claims Administrator and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to issue a determination. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(D) Post-Service Claims. In the case of a post-service claim, the Claims Administrator shall notify the Claimant of the benefit

determination (whether adverse or not) within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Claims Administrator for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Claims Administrator and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to issue its determination. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(iii) Notwithstanding the foregoing, with respect to a claim under the Health Care Flexible Spending Account Program or the Dependent Day Care Flexible Spending Account Program, if the Claims Administrator denies in whole or in part any claim for a benefit under the Plan, the Claims Administrator shall furnish the Claimant with written or electronic notice of the Adverse Benefit Determination not later than 30 days after receipt of the claim, unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, the Claimant shall be notified of such extension prior to the termination of the initial 30-day period. In no event shall such extension exceed the period of 15 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to issue its determination.

(iv) Notwithstanding the foregoing, with respect to a claim under the LTD and STD Participating Programs, if the Claims Administrator denies in whole or in part any claim for a benefit under the Plan, the Claims Administrator shall furnish the Claimant with written or electronic notice of the Adverse Benefit Determination not later than 45 days after receipt of the claim, unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, the Claimant shall be notified of such extension prior to the termination of the initial 45-day period. In no event shall such extension exceed the period of 60 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to issue its determination.

(v) Notwithstanding the foregoing, with respect to a claim under the LTC Participating Program, if the Claims Administrator denies in whole or in part any claim for a benefit under the Plan, the Claims Administrator shall furnish the Claimant with written or electronic notice of the Adverse Benefit Determination not later than 60 days after receipt of the claim, unless special circumstances require an extension of time for processing the claim. If such an extension of time

for processing is required, the Claimant shall be notified of such extension prior to the termination of the initial 60-day period. In no event shall such extension exceed the period of 60 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to issue its determination.

(b) Manner and Content of Notification of Initial Benefit Determination.

(i) The Claims Administrator shall provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification shall include, in a manner designed to be understood by the Claimant:

(A) the specific reason(s) for the Adverse Benefit Determination;

(B) reference to the specific Plan provisions on which the determination was based;

(C) a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary; and

(D) a description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on review.

(ii) In the case of an Adverse Benefit Determination under the Medical, Dental, Vision, LTD or STD Participating Programs, the notice shall also include:

(A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; and

(B) if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(iii) In the case of an Adverse Benefit Determination involving an urgent care claim under the Medical, Dental, or Vision Participating Programs,

the notice shall also include: (A) a description of the expedited review process applicable to such claims, and (B) the information described in paragraph (i) above may be provided to the Claimant orally, provided that a written or electronic notification in accordance with paragraph (i) above is furnished to the Claimant not later than three days after the oral notification.

11.3 Appeal Procedure. Except as provided in the applicable Program Document or to the extent Section 11.5 applies, a Claimant may request that the Claims Administrator designated to review appeals for a particular Participating Program (the “Appeals Administrator”) review the Adverse Benefit Determination by the Claims Administrator.

(a) Time for Filing Appeal.

(i) Except as otherwise required by paragraph (ii) below, such request shall be made in writing and shall be presented to the Appeals Administrator not more than 60 days after receipt by the Claimant of written notification of the Adverse Benefit Determination. All Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant’s claim for benefits. All Claimants shall also have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits, and the Appeals Administrator shall take into account all such information submitted without regard to whether such information was submitted or considered in the initial benefit determination.

(ii) In the case of an appeal under the Medical, Dental, Vision, LTD or STD Participating Programs, in addition to complying with paragraph (i) above:

(A) the 60-day appeal period under paragraph (i) above shall be extended to 180 days;

(B) the person or persons conducting the review shall neither be the Claims Administrator who made the Adverse Benefit Determination nor a subordinate of that Claims Administrator;

(C) the Appeals Administrator shall not give deference to the Claims Administrator’s initial Adverse Benefit Determination;

(D) in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Appeals Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(E) the Appeals Administrator shall identify the medical or vocational experts whose advice was obtained on behalf of the Claims

Administrator in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;

(F) the health care professional engaged by the Claims Administrator for purposes of a consultation under subparagraph (D) above shall be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and

(G) in the case of a claim involving urgent care under the Medical, Dental or Vision Participating Programs, a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant, and all necessary information, including the Appeals Administrator's benefit determination on review, shall be transmitted between the Appeals Administrator and the Claimant by electronic means, or other available and similarly expeditious method.

(b) Timing of Notification of Benefit Determination on Review.

(i) Except to the extent an accelerated review period is required by paragraphs (ii), (iii), (iv) or (v) below, the Appeals Administrator shall make its decision on review not later than 60 days after receipt of the Claimant's request for review, unless special circumstances require an extension of time, in which case written notice of the extension and circumstances shall be provided to the Claimant prior to the termination of the initial 60-day period and a decision shall be rendered as soon as possible but not later than 120 days after receipt of the request for review; provided, however, in the event the Claimant fails to submit information necessary to make a benefit determination on review, such period shall be tolled from the date on which the extension notice is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

(ii) In the case of an appeal under the Medical, Dental and Vision Participating Programs, the Appeals Administrator shall notify a Claimant of the benefit determination on review as follows:

(A) Urgent Care Claims. In the case of a claim involving urgent care, the Appeals Administrator shall notify the Claimant of the benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an Adverse Benefit Determination by the Appeals Administrator.

(B) Pre-Service Claims. In the case of a pre-service claim which does not involve urgent care, the Appeals Administrator shall notify the Claimant of the benefit determination on review within a reasonable

period of time appropriate to the medical circumstances. Such notification shall be provided not later than 30 days after receipt by the Appeals Administrator of the Claimant's request for review of an Adverse Benefit Determination.

(C) Post-Service Claims. In the case of a post-service claim, the Appeals Administrator shall notify the Claimant of the benefit determination on review within a reasonable period of time. Such notification shall be provided not later than 60 days after receipt by the Appeals Administrator of the Claimant's request for review of an Adverse Benefit Determination.

(iii) Notwithstanding the foregoing, with respect to an appeal under the Health Care Flexible Spending Account Program or the Dependent Day Care Flexible Spending Account Program, the Appeals Administrator shall notify a Claimant of the benefit determination on review not later than 60 days after receipt by the Appeals Administrator of the Claimant's request for review of an Adverse Benefit Determination.

(iv) Notwithstanding the foregoing, with respect to an appeal under the STD and LTD Participating Programs, the Appeals Administrator shall notify a Claimant of the benefit determination on review not later than 45 days after receipt by the Appeals Administrator of the Claimant's request for review of an Adverse Benefit Determination, unless special circumstances require an extension of time for processing the appeal. If such an extension of time for processing is required, the Claimant shall be notified of such extension prior to the termination of the initial 45-day period. In no event shall such extension exceed the period of 45 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Appeals Administrator expects to issue its determination.

(v) Notwithstanding the foregoing, with respect to an appeal under the LTC Participating Program, the Appeals Administrator shall notify a Claimant of the benefit determination on review not later than 60 days after receipt by the Appeals Administrator of the Claimant's request for review of an Adverse Benefit Determination, unless special circumstances require an extension of time for processing the appeal. If such an extension of time for processing is required, the Claimant shall be notified of such extension prior to the termination of the initial 60-day period. In no event shall such extension exceed the period of 60 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Appeals Administrator expects to issue its determination.

(c) Manner and Content of Notification of Appeal Determination.

(i) All decisions on review made by the Appeals Administrator shall be provided in writing or an electronic method in a manner designed to be

understood by the Claimant, and, in the case of an Adverse Benefit Determination, shall include the following:

(A) the specific reason(s) for the Adverse Benefit Determination;

(B) reference to the pertinent Plan provision(s) on which the decision was based;

(C) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, or other information relevant to the Claimant's claim for benefits; and

(D) a statement describing any voluntary appeal procedures offered by the Plan, and a statement of the Claimant's right to bring an action under Section 502(a) of ERISA.

(ii) With respect to an Adverse Benefit Determination involving a claim under the Medical, Dental, Vision, STD or LTD Participating Programs, the notice shall also include:

(A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion shall be provided free of charge to the Claimant upon request;

(B) if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation shall be provided free of charge upon request; and

(C) the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

11.4 Review of Denial on Appeal. Certain Participating Programs may provide for a review of the Claimant's denial of his or her appeal under Section 11.3. The procedures for such review (if any) shall be set forth in the applicable Program Document(s).

11.5 Review of Medical Participating Program Determinations. Notwithstanding Sections 11.2, 11.3 and 11.4 of the Plan, the claims and appeals procedures for each Medical Participating Program are set forth in the Program Documents, except that to the extent a Medical Participating Program is not a “grandfathered health plan” under PPACA and the applicable Program Documents for such Medical Participating Program do not contain the claims and appeals procedures applicable to non-grandfathered health plans under PPACA, the procedures described in this Section 11.5 shall apply. Unless otherwise stated, all notices must be provided in writing or by acceptable electronic means and in a culturally and linguistically appropriate manner (as determined under and to the extent required by PPACA) that is designed to be understood by the Claimant. Notwithstanding anything in this Section 11.5 to the contrary, to the extent the Department of Labor has provided enforcement relief with respect to the requirements of the internal claims and appeals procedures and external review requirements of PPACA (including, but not limited to, DOL Technical Releases 2010-1, 2010-2, 2011-1 and 2011-2), the applicable portions of this Section 11.5 shall not apply until the expiration of such enforcement relief. The terms of this Section 11.5 of the Plan are intended to comply with the requirements of PPACA and shall be administered in accordance with PPACA and any subsequent guidance issued thereunder with respect to the claims, appeals and/or external review procedures under the Medical Participating Programs that are not “grandfathered health plans” under PPACA.

(a) Initial Claim Determination. The provisions set forth in Section 11.2(a)(ii) shall apply under this Section 11.5, except that for purposes of determining whether a claim is an “urgent care” claim under Section 11.2(a)(ii)(A), the Claims Administrator shall defer to the determination of the Participant’s attending provider.

(b) Manner and Content of Notification of Initial Benefit Determination. The Claims Administrator shall provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification shall include, in a manner designed to be understood by the Claimant:

(i) information sufficient to identify the claim involved (i.e., the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code, the treatment code and the corresponding meanings of these codes);

(ii) the specific reason(s) for the Adverse Benefit Determination (including the denial code and its corresponding meaning);

(iii) a description the Plan’s standard, if any, that was used in denying the Claim;

(iv) reference to the specific Plan provisions on which the determination was based;

(v) a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(vi) a description of the Medical Participating Program's available internal appeals and external review processes (including information regarding how to initiate an appeal) and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on review;

(vii) information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793 to assist Claimants with the internal claims and appeals and external review processes;

(viii) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request;

(ix) if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(x) if the Adverse Benefit Determination relates to an urgent care claim, a description of the expedited review process applicable to urgent care claims.

(c) Appeal Procedure. A Claimant may request that the Appeals Administrator review the Adverse Benefit Determination by the Claims Administrator, provided that the Claimant makes such written request to the Appeals Administrator to appeal the Adverse Benefit Determination within 180 days of receiving the Adverse Benefit Determination.

(i) A Claimant may submit written comments, documents, records, and other pertinent information and, upon request and free of charge, will be given reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

(ii) The appeal will be conducted by an Appeals Administrator of the Plan who did not make the initial Adverse Benefit Determination and is not a subordinate of that Claims Administrator who made the Adverse Benefit Determination. The Appeals Administrator shall not give deference to the Claims Administrator's initial Adverse Benefit Determination and will take into account all comments, documents, records, and other information a Claimant submits relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

(iii) In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Appeals Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Appeals Administrator shall identify the medical or vocational experts whose advice was obtained on behalf of the Claims Administrator in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination. This health care professional will not be an individual who was consulted in connection with the initial benefit determination or the subordinate of any such individual.

(iv) The Appeals Administrator will also provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim and any new or additional rationale on which the appeal determination is based. Such evidence and/or rationale will be provided to the Claimant as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date.

(v) If the Claimant wishes to appeal an Adverse Benefit Determination relating to an urgent care claim, the Claimant may request an expedited appeal orally or in writing and all necessary information, including the Appeals Administrator's benefit determination on review, shall be transmitted between the Appeals Administrator and the Claimant by telephone, facsimile, or other available similarly expeditious method.

(vi) The Appeals Administrator shall notify a Claimant of the benefit determination on review as follows:

(A) In the case of an urgent care claim, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an Adverse Benefit Determination by the Appeals Administrator;

(B) In the case of a pre-service claim which does not involve urgent care, within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt by the Appeals Administrator of the Claimant's request for review of an Adverse Benefit Determination; and

(C) In the case of a post-service claim, the Appeals Administrator shall notify the Claimant of the benefit determination on review within a reasonable period of time, but not later than 60 days after

receipt by the Appeals Administrator of the Claimant's request for review of an Adverse Benefit Determination.

(vii) The Plan will provide continued coverage pending the outcome of a Claimant's appeal of an Adverse Benefit Determination to the extent required under PPACA.

(d) Manner and Content of Notification of Appeal Determination. All decisions on review made by the Appeals Administrator shall be provided in writing or an electronic method in a manner designed to be understood by the Claimant, and, in the case of an Adverse Benefit Determination, shall include the following:

(i) information sufficient to identify the claim involved (i.e., the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code, the treatment code and the corresponding meanings of these codes);

(ii) the specific reason(s) for the Adverse Benefit Determination (including the denial code and its corresponding meaning);

(iii) a description of the Plan's standard, if any, that was used in denying the claim (including a discussion of the decision);

(iv) reference to the pertinent Plan provision(s) on which the decision was based;

(v) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, or other information relevant to the Claimant's claim for benefits;

(vi) information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793 to assist Claimants with the internal claims and appeals and external review processes;

(vii) a description of any available voluntary appeal procedures offered by the Plan and any external review processes (including information regarding how to initiate an appeal), the time limits applicable to such procedures and processes, and a statement of the Claimant's right to bring an action under Section 502(a) of ERISA;

(viii) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion shall be provided free of charge to the Claimant upon request; and

(ix) if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation shall be provided free of charge upon request.

(e) External Review. A Claimant may file a request for an external review of an Adverse Benefit Determination within four months after the date of receipt of a notice of an Adverse Benefit Determination under this Section 7.5, as applicable. An Adverse Benefit Determination for purposes of this external review process does not include a determination that relates to a Claimant's failure to meet the requirements for eligibility under the terms of the Plan or Medical Participating Program.

(i) Preliminary Review. Within five business days following the receipt of the external review request, the Claims Administrator will complete a preliminary review of the request to determine whether:

(A) the Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

(B) the Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the Plan;

(C) the Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process; and

(D) the Claimant has provided all of the information and forms required to process an external review.

The Claims Administrator will provide the Claimant with a written notification within one business day after completion of its preliminary review. If the Claimant's request is complete but not eligible for external review, this notification will include the reasons for ineligibility and the contact information for the Employee Benefits Security Administration. If the request is not complete, this notification will describe the information or materials needed to make the request complete and the Claimant may perfect the request within the later of the four-month filing period or the 48-hour period following the receipt of the notification.

(ii) Referral to IRO. The Claims Administrator will assign an IRO to conduct any external review. The assigned IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review, including a statement that the Claimant may submit in writing to the assigned IRO within ten business days following the receipt of the notice additional information that the IRO will consider when conducting the external review. The Claims

Administrator will provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination within five business days after assigning the IRO. If the Claims Administrator fails to provide the documents and the information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination. In such case, the assigned IRO will notify the Claimant and the Claims Administrator within one business day of making such determination. The assigned IRO will forward to the Claims Administrator any information submitted by the Claimant within one business day after its receipt of the information and the Plan may reconsider its Adverse Benefit Determination. If the Claims Administrator decides to reverse its Adverse Benefit Determination upon reconsideration, the Plan will provide written notice of its decision to the Claimant and the assigned IRO within one business day of completing its reconsideration and the assigned IRO will terminate the external review upon receiving this notice.

(iii) IRO Review. The IRO will review de novo all of the information and documentation that it timely received. The assigned IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. This notice will be sent to the Claimant and the Plan and will contain: (A) a general description of the reason for the request for external review, including information sufficient to identify the claim (i.e., the date of service, the health care provider, the claim amount, and the diagnosis code, the treatment code and the corresponding meanings of these codes, and the reason for the previous denial); (B) the date the IRO received the assignment to conduct the external review and the date of the IRO decision; (C) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision; (D) a discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision; (E) a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to the Claimant; (F) a statement that judicial review may be available to the Claimant; and (G) current contact information, including the phone number for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

(iv) The IRO will maintain records of all claims and notices associated with the external review process for six years and such records will be available for examination by the Claimant, the Plan, or state or federal oversight agencies upon request (except to the extent such disclosure would violate state or federal privacy laws).

(v) Upon receipt of a notice of a final external review decision that reverses the Adverse Benefit Determination, the Plan will immediately provide coverage or payment for the Claimant's claim.

(f) Expedited External Review. A Claimant may file a request for an expedited external review at the time the Claimant receives an Adverse Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal or a standard external appeal would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function (provided the Claimant has filed a request for an internal appeal of an urgent care Claim) or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay or health care item or service for which the Claimant received emergency services but has not been discharged from a facility.

The Claims Administrator will immediately complete its preliminary review of the request for an expedited external review and must immediately send a notice to the Claimant of its determination regarding eligibility for external review. Upon determination that a request is eligible for external review, the Claims Administrator will assign an IRO and will provide or transmit all necessary documentation and information considered in making the Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documentation is available and the IRO considers them appropriate, must consider the information or documentation under the procedures for a standard external review. The IRO will provide notice of the final external review decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If this notice is not in writing, within 48 hours after providing that notice, the assigned IRO will provide written confirmation of the decision to the Claimant and to the Plan.

11.6 Claims Procedures for Non-ERISA Participating Programs. Claims for benefits under any Participating Program not subject to ERISA and not described in Sections 11.2 through 11.5 above will be reviewed by the Plan Administrator (or its delegate) and decided in a uniform and non-discriminatory manner. The claims and appeals procedures (if any) for such Participating Programs shall be set forth in the applicable Program Document(s) for such Participating Programs.

11.7 Calculating Time Periods. For purposes of this Article, the period of time within which a benefit determination is required to be made shall begin at the time the claim or appeal is filed with the Claims Administrator or the Appeals Administrator in accordance with the procedures of the Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event the Claims Administrator or the Appeals Administrator timely extends a period of time due to a Claimant's failure to submit information necessary to decide a claim or appeal, the period for making the benefit determination shall be tolled from the date on which the notification of extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

11.8 Processing of Claims. The Claims Administrator shall process a claim promptly after it receives complete written proof of the claim. The Claims Administrator may process an urgent care claim (as defined in Department of Labor Regulation 2560.503-1(m)) without a complete written proof of claim, provided that any benefit paid is conditioned upon the Claims

Administrator receiving a complete written proof of claim within a reasonable period of time thereafter. If the Claims Administrator finds that benefits are payable under the Plan, it shall send payment to the Claimant, unless such individual authorizes payment to be made directly to the provider of services or supplies.

11.9 Exhaustion of Administrative Remedies. Claimants shall not be entitled to challenge the Plan Administrator's (or Claims Administrator's or Appeals Administrator's) determinations in judicial or administrative proceedings without first complying with the administrative internal claims and appeals procedures and the external review procedures (to the extent applicable) set forth in the applicable Program Document or under this Article, as appropriate, within the applicable time limit based on the type of claim.

(a) The decisions made pursuant to the applicable administrative claims and appeals procedures under this Article are final and binding on the Claimant and any other party. If the Claimant has complied with and exhausted the appropriate internal claims and appeals procedures and intends to exercise his right to bring civil action under ERISA Section 502(a), the Claimant must bring such action before the earliest of: (a) six (6) months following the date on which he submitted the last required appeal (or voluntary appeal, if offered and the Claimant files a voluntary appeal) under such procedures, (b) three (3) years following the date the services related to the Claimant's claim for benefits were performed, or (c) the end of the applicable statutory limitations period. If the Claimant does not bring such action within the applicable time period set forth in the preceding sentence, the Claimant shall be barred from bringing an action under ERISA related to his claim.

(b) Notwithstanding anything in this Article XI to the contrary, if the Claims Administrator (or Appeals Administrator) fails to adhere to all the requirements of the internal claims and appeals process under the Medical Participating Program or Section 11.5 (as applicable) with respect to a claim, the Claimant is deemed to have exhausted the internal claims and appeals process, and upon such a failure, the Claimant may initiate an external review and pursue any available remedies under applicable law; provided, however, that the internal claims and appeals process shall not be deemed exhausted if the Claims Administrator's (or Appeals Administrator's) failure to adhere to all of the requirements of the internal claims and appeals process would be considered a de minimis violation that does not cause, and is not likely to cause, prejudice or harm or is due to matters beyond the control of the Claims Administrator (or Appeals Administrator) and that the violation(s) occurred in the context of an ongoing, good faith exchange of information between the Claims Administrator (or the Appeals Administrator) and the Claimant. Under such circumstances, the Claimant may request a written explanation and must be provided an explanation in response to such request within ten days of the request, including a specific description of the Claims Administrator's (or Appeals Administrator's) bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. Further, if the Claimant's request for external review is rejected based on the de minimis exception, the Claimant shall have the right to resubmit and pursue the internal appeal of the claim, and within a reasonable time of such rejection for external review (not to

exceed ten days), the Appeals Administrator shall provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim.

ARTICLE XII

ADMINISTRATION

12.1 Plan Administrator. The Plan Administrator is the named fiduciary and has complete discretionary control of the administration of the Plan and the Participating Programs, and will serve without additional remuneration, except for reimbursement of out-of-pocket expenses, for so long as it is mutually agreeable to the Plan Administrator and to the Plan Sponsor. The Company will have no duty or responsibility with respect to the administration of the Plan and the Participating Programs other than the appointment and removal of the Plan Administrator.

12.2 Duties and Powers of the Plan Administrator. The Plan Administrator will have full discretionary power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator's discretionary powers necessary to discharge its duties hereunder, include, but are not limited to, the following:

(a) To establish and enforce certain rules, regulations and procedures as it deems necessary or proper for the efficient administration of the Plan;

(b) In its sole discretion, to construe and interpret the Plan and Participating Programs (including any ambiguities) and decide all questions of fact, with its interpretations made in good faith to be final and conclusive, and to decide all questions concerning the Plan;

(c) To determine the eligibility of any employee to participate in the Plan, in its discretion, and to require any person to furnish any information as it may request to properly administer the Plan as a condition to that person receiving any benefit under the Plan;

(d) To determine the amount, manner and time of payment of any benefits that are payable to any Participant under the Plan. The Plan Administrator shall have the discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the application is entitled to them;

(e) To maintain records for each individual participant as to benefits, options, beneficiaries and other pertinent information;

(f) To prepare any reports required by the Plan, ERISA and the Code, as any of them may be amended from time to time;

(g) To file with the appropriate government agencies any and all reports and notifications required by the Plan or applicable law;

(h) To provide all Participants with any and all reports, notifications, summary plan descriptions, summaries of material modifications and summary annual reports to the extent required by law;

(i) To maintain appropriate accounts and records for the Plan and to keep in convenient form the data necessary for administering the Plan;

(j) To prescribe procedures to be followed by Participants and beneficiaries filing applications for benefits;

(k) To receive from the Participating Employers and from Participants, either directly or indirectly, such information as will be necessary for the proper administration of the Plan;

(l) To recoup overpayments from Participants in the Participating Programs;

(m) To designate, appoint or employ individuals to assist in the administration of the Plan and Participating Programs and any other agents (corporate or individual) it deems advisable, including legal counsel and such clerical, medical, accounting, auditing, actuarial and other services as it may require in carrying out the provisions of the Plan; and

(n) To discharge all other duties set forth herein as duties of the Plan Administrator.

To the extent that the administrative procedures or duties of the Plan Administrator conflict with the provisions of any Participating Program insurance contracts providing Plan benefits, the insurance contracts will govern. The Plan Administrator will have no power to terminate the Plan or the Participating Programs.

12.3 Examination of Records. The Plan Administrator will make available to each Participant such of his records under the Plan as pertain to him, for examination at reasonable times during normal business hours.

12.4 Rules and Decisions. The Plan Administrator will decide any matter and may adopt any rule or procedure regarding eligibility, benefits, claims, or any other issue arising under this Plan that the Plan Administrator deems necessary, desirable or appropriate in the administration of the Plan and the Participating Programs. All rules and decisions of the Plan Administrator will be uniformly and consistently applied to all Eligible Employees, Dependents and Participants in similar circumstances so that all persons similarly situated will receive substantially the same treatment, and will be conclusive and binding on all persons having an interest in the Plan or any Participating Program.

12.5 Delegation and Allocation of Responsibility of the Plan Administrator.

(a) The Plan Administrator may allocate or delegate any responsibility regarding the Plan and the Participating Programs provided to the Plan Administrator in this Plan document among one or more Claims Administrators and may designate other

persons, which persons may be either fiduciaries or persons other than fiduciaries, to carry out such responsibilities. Any such allocation or designation will be in writing. To the extent authority is given by the Plan or a Program Document, the document shall constitute an allocation or delegation. A Claims Administrator shall be a fiduciary with respect to any and all responsibilities allocated or delegated to such Claims Administrator by the Plan Administrator. The Claims Administrator shall have the discretionary authority to interpret the terms of the applicable Participating Program. Such discretionary authority shall include making factual determinations.

(b) The fiduciary or other person (or entity) to whom a responsibility of the Plan Administrator is allocated or delegated in accordance with subsection (a) will be responsible only for the performance of that responsibility according to the terms of the delegation or allocation and will not be liable for the act or omission of any other person with respect to the Plan unless:

(i) By his or her failure to properly administer the specific responsibility he or she has enabled such other person to commit a breach of fiduciary responsibility; or

(ii) He or she knowingly participates in or knowingly undertakes to conceal an act or omission of another person, knowing such act or omission to be a breach of fiduciary responsibility; or

(iii) Having knowledge of the breach of another, he or she fails to make reasonable efforts under the circumstances to remedy said breach.

(c) Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan and/or the Participating Programs.

12.6 Representations to Fiduciaries. Any person who is a fiduciary with respect to the Plan or the Participating Programs will be entitled to rely on representations made by Eligible Employees, Dependents, Participants, employees, beneficiaries, the Plan Sponsor, or the Claims Administrator of a Participating Program unless the fiduciary knows the representations to be false.

12.7 Plan Administrator's Decision Final. The Plan Administrator (or a Claims Administrator or other third-party administrator or entity to whom the Plan Administrator has allocated or delegated appeals authority) has the discretionary authority to determine eligibility for benefits under the Plan and each Participating Program, subject to the terms of the Participating Program and any underlying insurance contract. In the case of a self-insured Participating Program, the Claims Administrator or Appeals Administrator, as applicable, will have full discretionary authority to determine benefit claims and all appeals following an initial Adverse Benefit Determination (or series of benefit determinations as set forth in the claims procedures for the Participating Program). In the case of a fully insured Participating Program, the insurance company has discretionary authority to interpret the terms of the insurance policy and certificate and to decide benefit claims and all appeals following an initial Adverse Benefit Determination (or series of benefit determinations as set forth in the claims procedures for the

Participating Program) under the applicable contract. In such case, the insurance company or other Claims Administrator shall be the named fiduciary for purposes of such Participating Program, as permitted under Department of Labor Regulation 2560.503-1(g).

Subject to applicable law, any interpretation of the provisions of the Plan or any Participating Program and any decisions on any matter within the discretion of the Plan Administrator, the Claims Administrator or the insurance company will be conclusive and binding on all persons. A misstatement or other mistake of fact will be corrected when it becomes known to the parties, and adjustments to an account will be made in a manner such party considers equitable and practicable. The Plan Administrator, the Claims Administrator and/or any insurance company will not be liable in any manner for any determination of fact made in good faith.

12.8 Indemnity. To the fullest extent permitted by law, the Participating Employers will indemnify and hold harmless the Plan Administrator, each member of the Claims Committee, the Hearing Panel and any committee serving as the Plan Administrator, and each other employee, officer and director of the Company or any member of the Participating Employers, to whom fiduciary responsibilities are delegated under the Plan against any cost or expense (including attorneys' fees) or liability (including any sum paid in settlement of a claim with the approval of the Company) arising out of any act or omission to act, except in the case of willful misconduct or lack of good faith. The Participating Employers will not, however, indemnify the Plan Administrator with respect to any act finally adjudicated to have been caused by the willful misconduct or bad faith of such Plan Administrator, or with respect to the cost of any settlement unless the Plan Sponsor has approved the settlement. The right of indemnification will not be exclusive of any other right to which the Plan Administrator may be legally entitled and it will inure to the benefit of the duly appointed legal representatives of the Plan Administrator. The terms of this indemnification will also extend to any employees of the Plan Sponsor to whom any fiduciary responsibility has been assigned in connection with the administration of the Plan. The Plan Sponsor may obtain insurance to cover the cost of any indemnification.

12.9 Fiduciary Duties and Responsibilities. Each Plan fiduciary shall discharge his or her duties with respect to the Plan and Participating Programs solely in the interest of the Participants and their beneficiaries, for the exclusive purpose of providing benefits to such individuals and defraying reasonable expenses of administering the Plan, and in accordance with the terms of the Plan. Each fiduciary, in carrying out such duties, shall act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in exercising such authority.

(a) A fiduciary may serve in more than one fiduciary capacity. A named fiduciary may allocate any of the named fiduciary's responsibilities for the operation and administration of the Plan to other fiduciaries. Either the named fiduciary or other fiduciary appointed by the named fiduciary may employ one or more persons to render advice with regard to any responsibilities such fiduciary has under the Plan.

(b) Unless liability is otherwise provided under Section 405 of ERISA, a named fiduciary shall not be liable for any act or omission of any other party to the extent

that (i) such responsibility was properly allocated to the other party as a named fiduciary, or (ii) the other party has been properly designated to carry out such responsibility pursuant to the procedures set forth above.

ARTICLE XIII

HEALTH INFORMATION PRIVACY AND SECURITY

13.1 Applicability. This Article XIII applies to the Plan only to the extent that the Plan or any of the Participating Programs constitutes a “health plan” under 45 CFR 160.103 that uses or discloses “protected health information” (“PHI”) or “electronic protected health information” (“electronic PHI”) as those terms are defined under 45 CFR §§ 160 and 164, as amended from time to time (the “HIPAA Privacy Rules”) and 45 CFR §§ 160, 162 and 164, as amended from time to time (the “HIPAA Security Rule”). For purposes of this Article XIII, terms defined in the HIPAA Privacy Rules and the HIPAA Security Rule, but not in this Plan, shall be interpreted and administered in accordance with those provisions and the term “Plan” shall be interpreted to include this Plan and the Participating Programs to which this Article XIII applies. The HIPAA Privacy Rules and the HIPAA Security Rule shall include the HITECH Act and the regulations thereunder. For purposes of this Article XIII, the Plan Administrator shall interpret and administer terms defined in the HIPAA Privacy Rules and the HIPAA Security Rule in accordance with such rules.

13.2 Uses and Disclosures of PHI.

(a) Uses and Disclosures Generally.

(i) Permitted and Required Uses and Disclosures. The Privacy Officer shall use and disclose PHI in accordance with the HIPAA Privacy Rules, including to the extent that it determines that:

(A) such use or disclosure is needed for the “payment” of Participant claims, the “treatment” of Participants under the Plan, or the “health care operations” of the Plan, as such terms are defined in the HIPAA Privacy Rules, provided however, that the Plan shall not use or disclose PHI that is genetic information for underwriting purposes;

(B) such use or disclosure is required or permitted by law;

(C) such use or disclosure has been authorized by the relevant Participant(s) in accordance with the HIPAA Privacy Rules;

(D) such use or disclosure is appropriate under Section 13.3, Section 13.4, or Section 13.5; or

(E) such use or disclosure is made to a person involved, as determined by the Privacy Officer or Claims Administrator, in the relevant Participant’s care.

(ii) Certification by Plan Sponsor. Unless specifically permitted by law, the Privacy Officer shall not disclose any PHI to the Plan Sponsor unless: (A) such disclosure is to enable the Plan Sponsor to perform “plan administration functions” as described in the HIPAA Privacy Rules and (B) the Plan Sponsor has certified that this Plan document has been amended to incorporate the requirements of 45 CFR 164.504(f)(2)(ii) of the HIPAA Privacy Rules and has agreed to comply with these requirements.

(iii) No Other Uses or Disclosures. In no event shall the Privacy Officer or the Plan Sponsor use or disclose PHI for employment-related actions or decisions, in connection with any other benefit plan, or for any other purpose other than as required by law or as required or permitted by this Plan document. The Plan shall not disclose any Participant PHI to the Plan Sponsor unless Participants are provided with a notice of privacy practices that states such disclosures may be made.

(iv) Business Associates. To the extent required by law, the Privacy Officer shall not disclose PHI to a Claims Administrator or any other individual or entity that constitutes a “business associate” under the HIPAA Privacy Rules, except as provided under a “business associate agreement” that meets the requirements of the HIPAA Privacy Rules.

(v) Minimum Necessary. The Plan shall follow any guidance issued by the Department of Health and Human Services (“HHS”) regarding what constitutes “minimum necessary” with respect to the use or disclosure of PHI. Until the time that such guidance is issued, the Plan shall limit its uses or disclosures of PHI, to the extent practicable, to the “limited data set” (as defined in 45 CFR 164.514(e)(2)), or the minimum information necessary to accomplish the intended purpose of such use or request.

(vi) Authorization Required for Certain Uses or Disclosures. Except as permitted by the HITECH Act or the regulations and guidance issued thereunder, the Plan shall not directly or indirectly receive remuneration in exchange for any PHI or use or disclose PHI for marketing purposes unless the Plan first obtains a valid authorization from the Participant in accordance with the requirements for valid authorizations set forth in the HIPAA Privacy Rules, unless the marketing communication is made without any form of remuneration, for the purpose of describing medical services or products provided by the Plan, for treatment of the Participant, or for case management or care coordination for the Participant or to direct or recommend alternative treatments, therapies, providers or settings.

(b) Administrative Requirements.

(i) Separation of Plan Administration and Plan Sponsor. Access to PHI for Plan administration purposes shall be limited to (A) the Privacy Officer and contact person; (B) those individuals who, at the time of the relevant use or disclosure of PHI, are assigned to the Office of Human Resources of the Plan

Sponsor and are assigned to perform specific Plan administrative functions that involve the use or disclosure of PHI; and (C) employees who provide support to the Office of Human Resources, such as accountants and information system technicians. None of the individuals identified in the preceding sentence shall have access to PHI, except as reasonably necessary to perform the Plan administrative functions which are assigned or delegated to them. In case of any delegation, the individual to whom duties are assigned shall be required to comply with the provisions of this Article XIII. Beyond the individuals identified in this Section 13.2(b)(i), no other individuals employed by the Plan Sponsor shall have access to PHI.

(ii) Privacy Officer and Contact Person. The “Privacy Officer” of the Plan, who shall be appointed by the Plan Administrator or its designee in accordance with Article XIII, shall be responsible for the development and implementation of the Plan’s privacy policy (as provided in the HIPAA Privacy Rules) and administrative procedures. The contact person for the Plan, who shall be appointed by the Plan Administrator or the Privacy Officer, shall be responsible for receiving Participant complaints and responding to Participant requests for additional information about such policies and procedures. The Privacy Officer may delegate its duties as described in this Section 13.2 to the contact person, an individual designated as having access to PHI in accordance with Section 13.2(b)(i), or a business associate (including a Claims Administrator), to the extent necessary and appropriate for the proper and efficient administration of the Plan and compliance with the HIPAA Privacy Rules.

(iii) Noncompliance. Any individual identified in Section 13.2(b)(i) who fails to comply with the Plan’s privacy policy and related procedures shall be subject to the same disciplinary rules and procedures that apply to breaches of the employment policies of the Plan Sponsor, unless and until the Plan Administrator establishes specific rules for violation of the terms of this Article XIII.

(c) Legal Standards.

(i) Right to Revise Policies and Notice. To the fullest extent allowed by the HIPAA Privacy and Security Rules, the Privacy Officer shall be permitted to modify the privacy policy and/or the security policy and notify Participants of those modifications.

(ii) More Stringent State Law. This Plan shall be administered and interpreted to comply with any applicable state law regarding health information privacy and security, except to the extent that such state law is preempted by ERISA or HIPAA or another federal law.

(iii) Cooperate with HHS. The Privacy Officer shall disclose PHI, and its internal practices, books, and records, as required, to HHS for the purpose of

investigating or determining compliance with the HIPAA Privacy and Security Rules and the statutory provisions which they interpret.

13.3 Access and Copying of PHI.

(a) Access. Participant access to Participant PHI shall be governed by this Section 13.3 and 45 CFR 164.524. This Section applies to a Participant's PHI that is maintained by the Privacy Officer or a Claims Administrator, except: psychotherapy notes; information compiled with a reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding; and information that is not part of a "designated record set" as defined in the HIPAA Privacy Rules.

(b) Administration of Written Requests. A Participant may request access to, inspect, and copy his or her PHI using forms and procedures established by the Privacy Officer or Claims Administrator, as applicable. Such request may also be made by a personal representative (as described in the HIPAA Privacy Rules) of the Participant, in which case the provisions of this Section 13.3 will apply to the personal representative as if he or she were the Participant.

(i) If the requested PHI is maintained or accessible to the Privacy Officer or Claims Administrator on-site, the Privacy Officer or Claims Administrator will grant or deny the request in writing within 30 days of its receipt of the request, unless it is unable to do so and during that 30-day period provides the Participant with a written statement of the reasons for the delay and the date on which the Privacy Officer or Claims Administrator will grant or deny the request. In no event will this extension period exceed 30 days.

(ii) If the requested information is not maintained or accessible to the Privacy Officer or Claims Administrator on-site, the Privacy Officer or Claims Administrator will grant or deny the request in writing within 60 days of receipt of the request, unless it is unable to do so and during that 60-day period provides the Participant with a written statement of the reasons for the delay and the date on which the Privacy Officer or Claims Administrator will grant or deny the request. In no event will this extension period exceed 30 days.

(c) Request Granted. If the Privacy Officer or Claims Administrator grants a Participant's request to either inspect PHI or copy it, or both, the Privacy Officer or Claims Administrator will give the Participant such access to the PHI requested. If the PHI is requested in a format in which the PHI can be readily produced, then the PHI will be produced in that requested format. If the PHI cannot be readily produced in the requested format (as determined by the Privacy Officer or Claims Administrator), the Privacy Officer or Claims Administrator may provide it in readable hard copy format or some other form agreed to by the Participant. Alternatively, the Privacy Officer or Claims Administrator may provide the Participant with a summary or explanation of the requested PHI if the Participant agrees in advance to the summary or explanation format and the fee (if any) imposed for such summary or explanation. The Privacy Officer or Claims Administrator will arrange for access to the requested PHI to take place within the

time periods described in Section 13.3(b). The Privacy Officer will arrange a time and place for the Participant to access, inspect, and/or copy the PHI or will mail a copy of the PHI at the Participant's request. The Privacy Officer or Claims Administrator may impose a reasonable, cost-based fee for providing requested PHI if the fee includes only the cost for copying (both the supplies and labor), postage (if mailing of PHI is requested), and preparation of summaries or explanations (if agreed to as provided above).

(d) Request Denied.

(i) The Privacy Officer or Claims Administrator may deny a Participant's request and such denial will be considered final in the following cases: (A) the PHI is excepted from the right of access as specified in subparagraph (a) above; (B) the PHI is created or obtained in the course of ongoing research as described in the HIPAA Privacy Rules and the Participant consented to the restricted access when he or she agreed to participate in the research; (C) the PHI is contained in records subject to the Federal Privacy Act and may be denied under that Act; or (D) the PHI was obtained from someone other than a health care provider under a promise of confidentiality and access would be reasonably likely to reveal the source of the information.

(ii) The Privacy Officer or Claims Administrator may deny a Participant's request for access to PHI, provided that the Participant is allowed to have such denial reviewed, if a licensed health care professional, in the exercise of professional judgment, has determined that the access requested is: (A) reasonably likely to endanger the life or physical safety of the Participant or another person; (B) reasonably likely, if the PHI refers to another person, to cause substantial harm to that person; or (C) reasonably likely, if the access is requested by a Participant's personal representative, to cause substantial harm to the Participant or another person.

(iii) If the Privacy Officer or Claims Administrator partially denies a Participant's request for access to certain PHI under Section 13.3(d)(ii), the Privacy Officer or Claims Administrator will make other PHI requested available to the Participant. Additionally, if a request of PHI is denied (in whole or in part), the Privacy Officer or Claims Administrator will provide the Participant with a timely denial written in plain language and containing the basis for the denial; a statement of the Participant's review of denial rights (if applicable) and how to exercise those rights; and a description of how the Participant may submit a complaint. If the Privacy Officer or Claims Administrator does not maintain the PHI requested, but knows where it is maintained, the Privacy Officer or Claims Administrator must inform the Participant where the request should be directed.

(iv) If a Participant's request for access is denied under Section 13.3(d)(ii), the Participant may request to have the denial reviewed by a licensed health care professional whom the Privacy Officer or Claims Administrator has designated as the reviewing official and who did not participate in the original

decision to deny the request. The Privacy Officer or Claims Administrator will promptly refer the request for review to the designated reviewing official, who will then determine whether or not to deny the access requested based on the acceptable grounds for denial described in Section 13.3(d)(ii). The Privacy Officer or Claims Administrator will promptly provide written notice to the Participant of that determination and take action necessary to carry out this determination.

13.4 Amending PHI.

(a) Ability to Amend. A Participant's ability to amend his or her PHI shall be governed by this Section 13.4 and 45 CFR 164.526. This Section applies to a Participant's PHI that is maintained by the Claims Administrator or Privacy Officer, except: psychotherapy notes; information compiled with a reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding; or information that is not part of a "designated record set" as defined in the HIPAA Privacy Rules.

(b) Requests for Amendment and Plan Response. A Participant may request an amendment in writing, using forms and procedures established by the Privacy Officer or Claims Administrator, as applicable, if such request is supported by a reason to amend. Such request may also be made by a personal representative of the Participant, in which case the provisions of this Section 13.4 will apply to the personal representative as if he or she were the Participant. The Privacy Officer or Claims Administrator will act on the written request no later than 60 days after receipt of such request. If the Privacy Officer or Claims Administrator is unable to act within this time, it may extend the period for up to 30 days by providing the Participant with a written statement of the reason for the delay and the date by which the Privacy Officer or Claims Administrator will complete its action on the request.

(c) Amendment Granted. If the Privacy Officer or Claims Administrator grants the requested amendment (in whole or in part), it must make the appropriate amendment to the PHI or pertinent record. Such amendment will identify the affected PHI or records and append or otherwise provide a link to the location of the amendment. The Privacy Officer or Claims Administrator must also timely inform the Participant that the amendment is accepted and obtain the Participant's agreement to inform: (i) those identified by the Participant as having received the PHI and needing the amendment, and (ii) those known by the Privacy Officer or Claims Administrator to have received the PHI and that may foreseeably rely on the PHI to the detriment of the Participant.

(d) Amendment Denied

(i) Reasons for Denial. The Privacy Officer or Claims Administrator may deny a request for amendment if the PHI (A) was not created by, or on behalf of, the Plan (unless the Participant provides a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment); (B) is not part of a "designated record set" as defined in the HIPAA Privacy

Rules; (C) would not be available for Participant access under Section 13.3; or (D) is accurate and complete without the amendment.

(ii) Notice of Denial. If the Privacy Officer or Claims Administrator denies the request for amendment, it will send the Participant a denial written in plain language that contains a statement describing: (A) the basis for the denial; (B) the Participant's right to submit a written statement disagreeing with the denial and how such statement may be filed; (C) how, if a statement of disagreement is not filed, the Participant may request that the Privacy Officer or Claims Administrator include the request for amendment and the denial with any future disclosures of the PHI which is the subject of the requested amendment; and (D) the complaint procedures, including name or title and telephone number of the designated contact person or office.

(iii) Statement of Disagreement. If a Participant request for amendment is denied, the Participant may file a written statement of disagreement. Such statement must be of a reasonable length and must be filed using forms and procedures established by the Privacy Officer or Claims Administrator.

(iv) Rebuttal Statement. Whenever a Participant submits a statement of disagreement under Section 13.4(d)(iii), the Privacy Officer or Claims Administrator may prepare a written rebuttal to that statement. The Privacy Officer or Claims Administrator will provide a copy of that rebuttal to the affected Participant.

(v) Future Disclosures. The Privacy Officer or Claims Administrator will identify the PHI and append or otherwise link the amendment, denial, statement of disagreement, and rebuttal to the relevant records. The Privacy Officer or Claims Administrator will include such information, or an accurate summary of such information, with all future disclosures of the PHI if the Participant submitted a statement of disagreement. If the disclosure is made using a standard transaction that does not permit the material to be included with the disclosure, the Privacy Officer or Claims Administrator may transmit the material separately. If the Participant does not submit a statement of disagreement, the Privacy Officer or Claims Administrator will include the request for amendment and denial with future disclosures only if the Participant makes such a request. If the Privacy Officer or Claims Administrator receives notice from another "covered entity" (as defined in the HIPAA Privacy Rules) about an amendment to a Participant's PHI, the Privacy Officer or Claims Administrator must amend the PHI accordingly.

13.5 Accounting for Disclosures of PHI.

(a) Accounting of Disclosures. A Participant's ability to receive an accounting of disclosures of his or her PHI is governed by this Section 13.5 and 45 CFR 164.528. A Participant may request an accounting of disclosures of PHI made by the

Privacy Officer or Claims Administrator for any period less than six years prior to the date of the request unless the disclosure was: (i) to carry out treatment, payment and health care operations as provided in Section 13.2(a)(i)(A); (ii) to the Participant; (iii) to persons involved in the Participant's care or other notification purposes provided for in the HIPAA Privacy Rules; (iv) for national security or intelligence purposes; (v) to correctional institutions or law enforcement officials; or (vi) made pursuant to a valid Participant authorization. A request for an accounting of disclosures of a Participant's PHI may also be made by a personal representative of the Participant, in which case the provisions of this Section 13.5 will apply to the personal representative as if he or she were the Participant.

(b) Accounting for Disclosures of PHI Made Through Use of an Electronic Health Record. In accordance with the HITECH Act, if disclosures are made through the use of an electronic health record, a Participant may also request an accounting of disclosures made for treatment, payment and health care operations for any period less than three years prior to the date of the request as follows:

(i) If the Plan implements an electronic health record after January 1, 2009, then a Participant may request an accounting of such disclosures beginning on the later of January 1, 2011, or the date on which the Plan implements the electronic health record; or

(ii) If the Plan implemented an electronic health record prior to January 1, 2009, then a Participant may request an accounting of such disclosures beginning on or after January 1, 2014.

(c) Temporary Suspension. The Privacy Officer or Claims Administrator may temporarily suspend a Participant's ability to receive an accounting of disclosures made to a health oversight agency or law enforcement official if the accounting would be reasonably likely to impede the agency's or official's activities. The ability may only be suspended if the relevant agency or official provides the Privacy Officer or Claims Administrator with a written or oral statement specifying such impediment and the time for which the suspension is required. If this statement is an oral statement, the Privacy Officer or Claims Administrator will document the oral statement, including the identity of the agency or official making the statement; temporarily suspend the right to an accounting subject to the statement; and limit the suspension to no more than 30 days from the date of the oral statement unless a written statement is submitted during that time period.

(d) Content of the Accounting. For each disclosure made, the written accounting will include: the date of disclosure; the name and address of the recipient of the PHI; a brief description of the PHI disclosed; and the purpose of the disclosure. (In lieu of a description of the purpose of the disclosure, the Privacy Officer may provide a copy of the Participant's written authorization under the HIPAA Privacy Rules, or a copy of the written request for a disclosure pursuant to an HHS investigation or as permitted by the HIPAA Privacy Rules.) If the Privacy Officer or Claims Administrator makes multiple disclosures of PHI to the same person or entity for a single purpose, the

accounting prepared by the Privacy Officer or Claims Administrator need only include complete information for the first disclosure, and the frequency or number, including the date of the last such disclosure, for subsequent disclosures.

(e) Administrative Requirements. The Privacy Officer or Claims Administrator must act on the Participant's request for an accounting no later than 60 days after the receipt of such request. The Privacy Officer or Claims Administrator may extend this period for up to 30 additional days if it provides the Participant with a written statement of the reason for the delay and the date by which the accounting will be provided. The first accounting requested in any twelve-month period will be provided free of charge, but each subsequent request made within that same period will be charged a cost-based fee for completing the requested accounting. The Privacy Officer or Claims Administrator will inform the Participant of such fee in advance and provide the Participant the opportunity to withdraw or modify the request for a subsequent accounting.

13.6 Requests for Restrictions and Confidential Communications.

(a) Restrictions. Restrictions to Participant PHI shall be governed by this Section 13.6(a) and 45 CFR 164.522(a). Under this Section, a Participant may request that the Privacy Officer or Claims Administrator restrict uses or disclosures of PHI about the Participant to carry out treatment, payment or health care operations.

(i) Granting a Restriction. Subject to any exceptions contained in HIPAA, the HITECH Act or the regulations issued thereunder, the Privacy Officer or Claims Administrator is not required to agree to restriction. If the Privacy Officer or Claims Administrator agrees to a restriction, the Plan may not use or disclose the applicable PHI in violation of the restriction.

(ii) Disclosures to Family Members and Other Designated Individuals. The Privacy Officer or Claims Administrator will agree to a request by a Participant to refrain from disclosing such Participant's PHI to his or her family members or other individuals involved in the Participant's health care or payment for such care. If a Participant does not request such a restriction, the Privacy Officer or Claims Administrator may, in its administration of the Plan, disclose PHI to the applicable Participant's family members at such member's request.

(iii) Use or Disclosure of Restricted PHI. Even if the Privacy Officer or Claims Administrator agrees to the restriction, the PHI subject to the restriction may be disclosed if it is needed to provide emergency treatment, provided that the Privacy Officer or Claims Administrator requests that the recipient of the restricted PHI refrains from further disclosing the PHI. Also, a restriction shall not be effective for uses and disclosures requested by HHS or uses and disclosures for which the Participant would not otherwise have the opportunity to agree or object.

(iv) Terminating a Restriction. The Privacy Officer or Claims Administrator may terminate a restriction, if:

(A) the relevant Participant agrees to request the termination in writing;

(B) the relevant Participant orally agrees to the termination of the restriction if the Privacy Officer or Claims Administrator documents the oral agreement; or

(C) the Privacy Officer or Claims Administrator informs the relevant Participant that it is terminating its agreement to restrict PHI (provided that such restriction is not required by HIPAA, the HITECH Act or any regulations issued thereunder), except that such termination shall be effective only with respect to PHI created or received after it has so informed the Participant.

(b) Confidential Communications. Participant requests for confidential communications shall be governed by this Section 13.6(b) and 45 CFR 164.522(b). A Participant may request, in writing, to receive communications of PHI from the Privacy Officer or Claims Administrator by alternative means or at alternative locations. The Privacy Officer or Claims Administrator shall accommodate reasonable requests for confidential communications if such requests clearly state that the disclosure of all or part of that information could endanger the Participant.

13.7 Additional Obligations of Plan Sponsor.

(a) Compliance by Agents. Any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan must agree to the same restrictions and conditions that apply to the Plan Sponsor. Any contract between the Plan or Plan Sponsor and any agents or subcontractors providing services to the Plan which meet the definition of "business associate" under the HIPAA Privacy Rules must comply with the requirements of the HIPAA Privacy Rules.

(b) Report Improper Uses or Disclosures. If the Plan Sponsor becomes aware of any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in this Plan document or under the HIPAA Privacy Rules, the Plan Sponsor will report such use or disclosure to the Privacy Officer or its designee.

(c) Notify in the Event of a Breach of Unsecured PHI. The Plan will comply with the requirements of the HITECH Act and its implementing regulations to provide notification to affected individuals, HHS and the media (when required) if the Plan or one of its business associates discovers a Breach of Unsecured PHI (as defined in 45 CFR 164.402).

(d) Destroy PHI or Retain Protections. The Plan Sponsor must return or destroy all PHI received from the Privacy Officer that the Plan Sponsor still maintains in any form at the time when it is no longer needed for the purpose for which the disclosure

was made. If return or destruction is not feasible, the Plan Sponsor shall limit further uses and disclosures to those purposes that make return or destruction infeasible.

(e) Cooperate With HHS. The Plan Sponsor shall disclose PHI, its internal practices, books, and records, as required, to HHS for purposes of investigating or determining compliance with the HIPAA Privacy Rules and their underlying statutory provisions.

13.8 Health Information Security.

(a) General. The rules in this Section 13.8 govern the security of PHI under the Plan. This Section 13.8 is intended to demonstrate good faith compliance with the health information security requirements of the HIPAA Security Rule and is to be construed in accordance with HIPAA, the HITECH Act and the guidance and regulations issued thereunder. For purposes of this Section 13.8, terms defined in the HIPAA Security Rule but not in this Plan shall be interpreted and administered in accordance with the HIPAA Security Rule.

(b) Security Officer. The security officer of the Plan shall be appointed by the Plan Administrator and shall be responsible for the development and implementation of the Plan's security policies (as required by the HIPAA Security Rule) and administrative, technical and physical safeguards to protect the integrity and security of electronic PHI. If the Plan Administrator fails to appoint a security officer, the Plan Administrator shall serve as security officer of the Plan.

(c) HIPAA Security Rule Compliance. In accordance with HIPAA, the Plan Sponsor shall:

(i) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that is created, received, maintained, or transmitted on behalf of the Plan;

(ii) ensure that adequate separation, as required by the HIPAA Security Rule, is supported by reasonable and appropriate security measures;

(iii) require any agent, including a subcontractor, to whom it provides this information to agree to implement reasonable and appropriate security measures to protect the electronic PHI;

(iv) report to the Plan any successful unauthorized access, use, disclosure, modification or destruction of electronic PHI or interference with system operations in an information system containing PHI of which the Plan Administrator becomes aware; and

(v) report to the Plan the aggregate number of unsuccessful attempts to access, use, disclose, modify or destroy electronic PHI, or interfere with systems

operations in an information system containing PHI, of which the Plan Sponsor becomes aware.

ARTICLE XIV

AMENDMENT OR TERMINATION

14.1 Employer Not Committed to Permanent Welfare Benefits. No provision in this Plan document, including any Supplements or Program Documents incorporated by reference through any Supplement, is intended to commit the Company or any of the Participating Employers to the provision of permanent welfare benefits of any type to any class of employees or their dependents, or to the maintenance of the Plan or any Participating Program.

14.2 Right to Amend. By written action of the Board of Directors of the Company or the Senior Vice President of Human Resources (or if no individual is serving in the capacity of Senior Vice President of Human Resources, such other person serving in the role of the head of human resources or as appointed by the Chief Executive Officer of the Company), the Plan Sponsor reserves the discretionary right to modify or amend the Plan, including any Supplement hereto, in any respect, at any time and from time to time, retroactively or otherwise, subject only to any limitations set forth by the Compensation Committee of the Board of Directors of the Company. Notwithstanding the foregoing, the Senior Vice President of Human Resources (or if no individual is serving in the capacity of Senior Vice President of Human Resources, such other person serving in the role of the head of human resources or as appointed by the Chief Executive Officer of the Company) may amend one or more Participating Programs through the issuance of a revised summary plan description (or a summary of material modifications) to the extent that such amendment is permitted under the authority granted to such person by the Compensation Committee of the Board of Directors of the Company.

14.3 Right to Terminate. The Plan Sponsor will have the sole authority to terminate part or all of the Plan and/or any Participating Program as to some or all classes of employees or their dependents, at any time. All terminations will be made by a written action of the Board of Directors of the Company or the Senior Vice President of Human Resources (or if no individual is serving in the capacity of Senior Vice President of Human Resources, such other person serving in the role of the head of human resources or as appointed by the Chief Executive Officer of the Company), subject only to any limitations set forth by the Compensation Committee of the Company's Board of Directors.

14.4 Dissolution, Merger, Consolidation or Reorganization of Plan Sponsor. In the event of dissolution, merger, consolidation or reorganization of the Plan Sponsor, the Plan and all Participating Programs shall terminate. However, if arrangements are made for the continuation of the Plan and any or all Participating Programs by any successor to the Plan Sponsor or any purchaser of all or substantially all of the Plan Sponsor's assets (or as may otherwise be appropriate or desirable under applicable circumstances), then the successor or purchaser (or other applicable entity) will be substituted for the Plan Sponsor under the Plan and such Participating Programs.

14.5 Notice of Termination. Affected Participants will be notified of any termination of a Participating Program or of the Plan within a reasonable time. Upon the termination of a Participating Program or the Plan, any benefit rights of such Participants shall become payable as the Plan Administrator may direct.

ARTICLE XV

PARTICIPANT RIGHTS AND RESPONSIBILITIES

15.1 No Enlargement of Employee Rights. Nothing in the Plan or the Participating Programs will be deemed to give an Eligible Employee, Participant, or Employee the right to be retained in the service of a Participating Employer or to interfere with any right of the Participating Employer to discharge such person.

15.2 No Assignment. Except as may otherwise be specifically provided in (a) the Plan, (b) the Program Documents, or (c) applicable law, a Participant's rights, interests or benefits under the Plan or the Participating Programs will not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the Participating Programs, and any such attempt will be void.

15.3 Divestment of Benefits. Subject only to the specific provisions of this Plan and the underlying Program Documents, nothing shall be deemed to divest a Participant of a right to the benefit to which the Participant becomes entitled in accordance with the provisions of this Plan.

15.4 Qualified Medical Child Support Order. Notwithstanding anything in the Plan or any Participating Program to the contrary, if the Plan Administrator receives a "qualified medical child support order" (as defined in Section 609 of ERISA) relating to medical, dental or vision benefits, such benefits will be provided under the applicable Participating Programs to the alternate recipient(s) (as defined in Section 609 of ERISA) specified in the order, but only to the extent such benefits are provided for in the applicable Participating Programs. An alternate recipient entitled to benefits under the applicable Participating Programs in accordance with a qualified medical child support order cannot be a former spouse, domestic partner or dependent of a domestic partner. The Plan Administrator will adopt a written procedure to determine whether a medical child support order is a qualified medical child support order and may establish additional rules for implementing this Section 15.4, so long as those rules are consistent with Section 609 of ERISA and any regulations thereunder. The Plan Administrator will provide copies of these procedures to Participants and alternate recipients (or their authorized representatives) as required by applicable law.

15.5 Subrogation and Third Party Reimbursement.

(a) If a Participant or any other person receives a recovery in any form, including (but not limited to) a judgment, settlement, payment or compensation of any type with respect to an injury or condition for which the Plan has provided benefits or advanced money (regardless of fault, negligence or wrongdoing) from any tortfeasor,

liability insurer, uninsured or underinsured motorist insurer, medical program coverage or other source (a "Recovery"), the Participant or such other person must repay the Plan in full for any benefits that have been or may be paid, payable or advanced by the Plan (the "Subrogated Amount"), including any reasonably foreseeable expenses not yet incurred, whether or not the Participant or such other person has been "made whole" for the injuries or condition suffered.

(b) Each person receiving benefits or advanced money from the Plan has an obligation and duty to reimburse the Plan to the extent of the Subrogated Amount and is deemed to give the Plan a first lien on any Recovery for the Subrogated Amount. The Plan may also, in its sole discretion, seek to impose a constructive trust through the courts on a Recovery to the extent of the Subrogated Amount. This right of first priority in contravention of any "make whole" doctrine shall not be affected or limited in any way by the manner in which the person or entity responsible for paying any Recovery designates or characterizes the Recovery. The Plan specifically disclaims the "common fund doctrine" and any payment of the Subrogated Amount to the Plan shall be without reduction, set-off or abatement for attorneys' fees or costs incurred by the Participant or any other person in obtaining the recovery. The Participant or any other claimant of a Recovery must promptly inform the Plan of the filing of a lawsuit, making a claim against any third party, the scheduling of settlement negotiations or the intention of any third party to make payment of any kind to the Participant or claimant's benefit or on his or her behalf to which this Section may reasonably apply. If it is determined that a third-party may be responsible for the payment of benefits paid or money advanced by the Plan, the Participant or any other person may be contacted by the Plan or its representative to provide information regarding any potential Recovery, and the Participant or such other person consents to being so contacted and shall agree to cooperate in obtaining any Recovery. The Participant and any other person who may receive a potential Recovery shall segregate and hold any Recovery in a separate fund for the purpose of reimbursing the Plan the Subrogated Amount until such time as the Subrogated Amount has been reimbursed by the Plan.

(c) The Plan may, in its sole discretion, require the Participant or any other person, as a precondition of payment of benefits or advance of money, to sign a written assignment of any Recovery to the Plan to the extent of the Subrogated Amount. In the event that the Plan does not receive payment of the Subrogated Amount, the Plan and the Plan Administrator have the full discretion and authority, either together or individually, to bring any action against the Participant or any other person who has received or may receive a Recovery in any capacity or against any person responsible for the injuries or condition suffered or for the payment of any potential Recovery, or reduce or set-off the Subrogated Amount against future benefit payments. Such action may include filing suit against the Participant or such other person in a court of law to recover 100% of the Subrogated Amount plus the Plan's attorneys' fees and court costs related to such suit.

(d) Except as otherwise provided in the Plan or as required by applicable law, the Plan is not required to pay any expenses for past illnesses or injuries that are settled where the Participant or another person have received a Recovery, and the Plan's rights

of subrogation and reimbursement of the Subrogated Amount apply even if the original injury or illness happened before coverage under the Plan began.

(e) The payment of benefits under the Plan is conditioned upon the terms of this Section and each person receiving benefits or advanced money from the Plan shall agree that such benefits or money is paid or advanced on condition of full reimbursement to the Plan in the event of a Recovery. By accepting any benefits under the Plan, the Participant agrees to repay the Subrogated Amount. The Plan's rights to subrogation and reimbursement of the Subrogated Amount will not be reduced by any equitable defenses that may be raised by the Participant or any third party (whether such third party has received benefits or is responsible for payment of a Recovery), including, but not limited to, any common fund doctrine, contributory negligence doctrine, make whole doctrine or uninsured motorist rules or statutes. If any court of competent jurisdiction finds any portion of this Section void or unenforceable, such portion shall be of no force and effect but shall not affect the validity or enforceability of any other portion thereof.

15.6 Benefit Coordination. If an individual claiming benefits under the Medical or Dental Participating Program is covered under two or more plans (including the Plan and/or a Participating Program), the order in which benefits shall be determined according to the following:

(a) If a Spouse or Domestic Partner is covered under the Medical or Dental Participating Program as a Dependent and the Spouse or Domestic Partner is covered under another medical or dental plan, the other medical or dental plan shall have the primary benefit payment responsibility. If such other medical or dental plan pays benefits that are less than the amount the Medical or Dental Participating Program would pay, the Medical or Dental Participating Program will pay up to the extent that total payments from both the other plan and the Medical or Dental Participating Program do not exceed the amount the Medical or Dental Participating Program would have paid.

(b) The plan that covers the individual as an employee shall have the primary benefit payment responsibility. The plan that covers the individual as a dependent shall have secondary benefit payment responsibility.

(c) With respect to coverage of an eligible Dependent Child, if the child's parents are neither legally separated nor divorced, the plan of the parent whose birthday falls earlier in the year will have primary benefit payment responsibility, and the plan of the parent whose birthday falls later in the year will have secondary payment responsibility. If both parents have the same birthday, then the plan of the parent who has been covered longer will have primary payment responsibility.

(d) With respect to coverage of an eligible Dependent Child whose parents are either legally separated (whether or not ever married) or divorced, the plan of the parent having custody of the child will have primary payment responsibility and the plan of the parent not having custody will have secondary benefit payment responsibility. The plan of a stepparent who has custody shall have primary benefit payment responsibility over the parent who does not have custody. However, if there is a court decree specifying the

financial responsibility for the health care expenses of the child, then the plan of the parent having such responsibility will have primary benefit payment responsibility.

15.7 Benefit Coordination with Medicare. With respect to the Medical Participating Program, Medicare shall automatically be the primary coverage for the Medicare-eligible Participants who are no longer currently employed by a Participating Employer, but for Medicare-eligible Participants who are currently employed by a Participating Employer, the Plan shall be the primary coverage, subject to the “secondary payer” rules under Medicare. If an Eligible Employee’s Dependent is Medicare-eligible due to a disability, the Plan shall be the primary coverage, provided such Dependent is covered under the Plan due to the Eligible Employee’s current employment status as determined under the Medicare “secondary payer” rules. Notwithstanding the foregoing, coordination of Medical Participating Program benefits with Medicare shall be determined in accordance with applicable federal regulations describing the order of benefit determination with respect to primary and secondary coverage.

15.8 Right to Receive and Release Necessary Information. For the purposes of applying and implementing the terms of this Plan or any Participating Program, the Plan Administrator may, without the consent of or notice to any person (subject to the HIPAA Privacy Rules, the HIPAA Security Rules and any other applicable law), release or obtain from any other organization or person any information with respect to any person that he or she deems to be necessary for these purposes. Any person claiming benefits under this Plan or any Participating Program must furnish to the Plan Administrator any information necessary to implement this Plan or the relevant Participating Program.

15.9 Rights to Employer’s Assets. No Participant or beneficiary shall have any right to, or interest in, any assets of a Participating Employer upon termination of employment or otherwise, except as provided from time to time under this Plan, and then only to the extent of the benefits payable under the Plan to such Participant or beneficiary. Nothing herein shall require a Participating Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Participating Employer from which any payment under the Plan may be made.

15.10 No Guarantee of Tax Consequences. Neither the Plan Administrator nor any Participating Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant’s gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant’s gross income for federal and state income tax purposes, and to notify a Participating Employer if the Participant has reason to believe that any such payment is not so excludable.

15.11 Notice of Address. Each person entitled to benefits under one or more Participating Programs must file with the Plan Sponsor, in writing, his or her mailing address and each change of mailing address. Any communication, statement or notice addressed to such person at such address will be deemed sufficient for all purposes of the Plan and the Participating

Programs, and there will be no obligation on the part of the Plan Sponsor, the Plan Administrator, or any insurer to search for or to ascertain the location of such person.

15.12 Recovery of Benefit Overpayment. If any benefit from or any Compensation Reduction Amount for a Participating Program paid to or on behalf of a Participant should not have been paid or should have been paid in a lesser amount or should have been paid but was not, and the Participant fails to repay the amount promptly, then the overpayment may be recovered by the Plan Administrator to the extent permitted by law from any monies then payable, or which may become payable, in the form of salary, wages or benefits payable under any employer-sponsored benefit programs, including the applicable Participating Program. An overpayment includes any benefits provided for a Dependent whose coverage is terminated under Section 3.2 because the Plan Administrator determines that the individual is not an eligible Dependent due to the individual's failure to provide the Plan Administrator with the information necessary to determine the individual's status as a Dependent or due to the provision of false or misleading information to the Plan Administrator regarding the individual's status as a Dependent. The Plan Administrator also reserves the right to recover any such overpayment by appropriate legal action.

ARTICLE XVI

MISCELLANEOUS

16.1 Severability. If any provision of the Plan or any Participating Program is held by a court of competent jurisdiction to be invalid or unenforceable, such invalid or unenforceable provision shall be severed from the Plan and the Plan shall operate without regard to such severed provision. The remaining provisions of the Plan or of any Participating Program will continue to be fully effective.

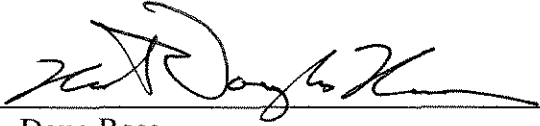
16.2 Contracts and Agreements. Any contracts or agreements with health care networks, insurance companies or other entities entered into by the Plan Administrator with the sole purpose of providing for the administration and/or the delivery of benefits under a Participating Program will be initiated, continued or terminated at the sole discretion of the Plan Administrator. The Plan Administrator reserves the right to change insurance carriers and health care networks at any time. The Plan Administrator further reserves the right to change between fully insuring and self-insuring benefits at any time. Administrative agreements between third party administrators and the Plan are separate business agreements and are not part of this Plan document or any underlying Participating Program.

16.3 Resolution of Conflicts. To the extent that there is a conflict between the Plan document and the Program Documents incorporated herein by reference, the terms of the Plan document will control. However, in the case of issues relating to fully insured benefits, the applicable insurance policy and certificate will control to the extent that they do not conflict with applicable state or federal law.

16.4 Application of State Law. Except as otherwise preempted by federal law, this Plan will be administered, construed, and enforced according to the laws of the State of Illinois and in courts situated in Illinois.

IN WITNESS WHEREOF, The Company has caused this duly adopted Plan to be executed below by its duly authorized representative on this 16th day of December, 2013.

DISCOVER FINANCIAL SERVICES

By: 
Doug Rose

Its: Senior Vice President, Chief Human Resources Officer

SUPPLEMENT A
PARTICIPATING PROGRAMS

The terms and provisions of the following Participating Programs are hereby incorporated into by reference and made a part of the Plan. For fully insured Participating Programs, those terms and provisions are found in the applicable insurance policy or HMO agreement, along with the applicable sections of the summary plan descriptions ("SPDs") and summaries of material modifications ("SMMs") indicated below. For self-insured Participating Programs, those terms and provisions are found in the applicable sections of the SPDs and SMMs indicated below. The following Participating Programs comprise the Plan:

Participating Program: TPA or Insurer/Benefit Option	Incorporated Program Documents
<p>Medical (including Prescription Drug):</p> <ul style="list-style-type: none"> • BCBS High Deductible Plan with Health Reimbursement Arrangement (BCBS HRA); CVS Caremark (for prescription drug coverage) • BCBS with Health Savings Account (BCBS Choice Plus HSA); CVS Caremark (for prescription drug coverage) • BCBS PPO (BCBS PPO); CVS Caremark (for prescription drug coverage) • Hawaii Medical Service Association (HMSA) Medical Plan (for Hawaii employees) • SelectHealth HMO (for Utah employees) • Kaiser HMO (for California employees) • Connect Your Care (HSA administration) 	<p>Select Health Certificate of Coverage 2012</p> <p>Select Health (SelectMed HMO) Group Health Insurance Contract No. G 1007059</p> <p>HMSA Group Plan Summary 2011, Group Plan Number 11487-1-7</p> <p>ASHI Certificate of Group Insurance, Policy Number 13668-00</p> <p>Services Agreement - Connect Your Care — 1/1/2012</p> <p>Blue Cross Blue Shield of Illinois Administrative Service Agreement ("ASA") between Blue Cross Blue Shield of Illinois and Discover Financial Services</p> <p>Kaiser Permanente Group Health Insurance Contract No. 231121</p> <p>Form of Participating Group Addendum (for PBM services provided through an agreement between Hewitt Associates and Caremark PCS Health)</p> <p>Welfare Benefits Plan SPD</p> <p>SMMs: Quick Start 2009 Enrollment Guide and 2009 Benefit Plan Features and Rates</p> <p>SMM: Enrollment 2010 Quick Start Guide and Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 6/1/2010</p> <p>SMM: Benefits Central is Changing — 9/1/2010</p> <p>SMM: Annual Enrollment for 2011 Quick Start Guide Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 1/1/2011</p> <p>SMM: Annual Enrollment for 2012 Benefits</p> <p>SMM: Annual Enrollment for 2013 Benefits</p> <p>SMM: Annual Enrollment for 2014 Benefits</p>

Participating Program: TPA or Insurer/Benefit Option	Incorporated Program Documents
Dental (MetLife): <ul style="list-style-type: none"> • Standard Option • Premier Option 	<p>MetLife Dental Certificate of Coverage for Louisiana, Mississippi, Montana</p> <p>MetLife Dental Standard Option Certificate of Insurance</p> <p>MetLife Dental Premier Option Certificate of Insurance</p> <p>Welfare Benefits Plan SPD</p> <p>SMMs: Quick Start 2009 Enrollment Guide and 2009 Benefit Plan Features and Rates</p> <p>SMM: Enrollment 2010 Quick Start Guide and Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 6/1/2010</p> <p>SMM: Benefits Central is Changing — 9/1/2010</p> <p>SMM: Annual Enrollment for 2011 Quick Start Guide, Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 1/1/2011</p> <p>SMM: Annual Enrollment for 2012 Benefits</p> <p>SMM: Annual Enrollment for 2013 Benefits</p> <p>SMM: Annual Enrollment for 2014 Benefits</p>

Participating Program: TPA or Insurer/Benefit Option	Incorporated Program Documents
Vision (VSP VisionCare): <ul style="list-style-type: none"> • Standard Option • Premier Option 	<p>Group Vision Care Agreement, Policy 12309573</p> <p>Welfare Benefits Plan SPD</p> <p>SMMs: Quick Start 2009 Enrollment Guide and 2009 Benefit Plan Features and Rates</p> <p>SMM: Enrollment 2010 Quick Start Guide and Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 6/1/2010</p> <p>SMM: Benefits Central is Changing — 9/1/2010</p> <p>SMM: Annual Enrollment for 2011 Quick Start Guide, Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 1/1/2011</p> <p>SMM: Annual Enrollment for 2012 Benefits</p> <p>SMM: Annual Enrollment for 2013 Benefits</p> <p>SMM: Annual Enrollment for 2014 Benefits</p>
Health Care Flexible Spending Account Program (through Connect Your Care):	<p>Welfare Benefits Plan SPD</p> <p>SMMs: Quick Start 2009 Enrollment Guide and 2009 Benefit Plan Features and Rates</p> <p>SMM: Enrollment 2010 Quick Start Guide and Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 6/1/2010</p> <p>SMM: Benefits Central is Changing — 9/1/2010</p> <p>SMM: Annual Enrollment for 2011 Quick Start Guide, Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 1/1/2011</p> <p>SMM: Annual Enrollment for 2012 Benefits</p> <p>SMM: Annual Enrollment for 2013 Benefits</p> <p>SMM: Annual Enrollment for 2014 Benefits</p>

Participating Program: TPA or Insurer/Benefit Option	Incorporated Program Documents
Dependent Day Care Flexible Spending Account Program (through Connect Your Care)	<p>Welfare Benefits Plan SPD</p> <p>SMMs: Quick Start 2009 Enrollment Guide and 2009 Benefit Plan Features and Rates</p> <p>SMM: Enrollment 2010 Quick Start Guide and Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 6/1/2010</p> <p>SMM: Benefits Central is Changing — 9/1/2010</p> <p>SMM: Annual Enrollment for 2011 Quick Start Guide Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 1/1/2011</p> <p>SMM: Annual Enrollment for 2012 Benefits</p> <p>SMM: Annual Enrollment for 2013 Benefits</p> <p>SMM: Annual Enrollment for 2014 Benefits</p>
Life Insurance (Minnesota Life): <ul style="list-style-type: none"> • Basic Coverage • Supplemental Coverage 	<p>Minnesota Life Group Term Life Insurance Policy #33953-G</p> <p>Minnesota Life Employee Group Term Life Certificate of Insurance #33953-G</p> <p>Welfare Benefits Plan SPD</p> <p>SMMs: Quick Start 2009 Enrollment Guide and 2009 Benefit Plan Features and Rates</p> <p>SMM: Enrollment 2010 Quick Start Guide and Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 6/1/2010</p> <p>SMM: Benefits Central is Changing — 9/1/2010</p> <p>SMM: Annual Enrollment for 2011 Quick Start Guide, Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 1/1/2011</p> <p>SMM: Annual Enrollment for 2012 Benefits</p> <p>SMM: Annual Enrollment for 2013 Benefits</p> <p>SMM: Annual Enrollment for 2014 Benefits</p>

Participating Program: TPA or Insurer/Benefit Option	Incorporated Program Documents
Accidental Death and Dismemberment Insurance (Life Insurance Company of North America): <ul style="list-style-type: none">• Basic Accidental Death and Dismemberment Insurance• Supplemental Accidental Death and Dismemberment Insurance	<p>Life Insurance Company of North America OK980092 Basic Accidental Death and Dismemberment Benefits and OK980085 Voluntary Accidental Death and Dismemberment Benefits (Supplemental)</p> <p>Welfare Benefits Plan SPD</p> <p>SMMs: Quick Start 2009 Enrollment Guide and 2009 Benefit Plan Features and Rates</p> <p>SMM: Enrollment 2010 Quick Start Guide and Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 6/1/2010</p> <p>SMM: Benefits Central is Changing — 9/1/2010</p> <p>SMM: Annual Enrollment for 2011 Quick Start Guide Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 1/1/2011</p> <p>SMM: Annual Enrollment for 2012 Benefits</p> <p>SMM: Annual Enrollment for 2013 Benefits</p> <p>SMM: Annual Enrollment for 2014 Benefits</p>

Participating Program: TPA or Insurer/Benefit Option	Incorporated Program Documents
Business Travel Accident Insurance (Life Insurance Company of North America)	<p>Life Insurance Company of North America Group Business Travel Accident Insurance Policy Number: ABL654490</p> <p>Welfare Benefits Plan SPD</p> <p>SMMs: Quick Start 2009 Enrollment Guide and 2009 Benefit Plan Features and Rates</p> <p>SMM: Enrollment 2010 Quick Start Guide and Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 6/1/2010</p> <p>SMM: Benefits Central is Changing — 9/1/2010</p> <p>SMM: Annual Enrollment for 2011 Quick Start Guide Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 1/1/2011</p> <p>SMM: Annual Enrollment for 2012 Benefits</p> <p>SMM: Annual Enrollment for 2013 Benefits</p> <p>SMM: Annual Enrollment for 2014 Benefits</p>
Short-Term Disability (Hewitt Associates)	<p>Welfare Benefits Plan SPD</p> <p>First Amendment to the Hewitt Administrative Services Agreement</p> <p>SMMs: Quick Start 2009 Enrollment Guide and 2009 Benefit Plan Features and Rates</p> <p>SMM: Enrollment 2010 Quick Start Guide and Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 6/1/2010</p> <p>SMM: Benefits Central is Changing — 9/1/2010</p> <p>SMM: Annual Enrollment for 2011 Quick Start Guide Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 1/1/2011</p> <p>SMM: Annual Enrollment for 2012 Benefits</p> <p>SMM: Annual Enrollment for 2013 Benefits</p> <p>SMM: Annual Enrollment for 2014 Benefits</p>

Participating Program: TPA or Insurer/Benefit Option	Incorporated Program Documents
Long-Term Disability (CIGNA)	<p>Life Insurance Company of America Consulting and Services Agreement — 11/12/2010</p> <p>Life Insurance Company of America Group Insurance Policy #VDT-980047</p> <p>Welfare Benefits Plan SPD</p> <p>SMMs: Quick Start 2009 Enrollment Guide and 2009 Benefit Plan Features and Rates</p> <p>SMM: Enrollment 2010 Quick Start Guide and Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 6/1/2010</p> <p>SMM: Benefits Central is Changing — 9/1/2010</p> <p>SMM: Annual Enrollment for 2011 Quick Start Guide Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 1/1/2011</p> <p>SMM: Annual Enrollment for 2012 Benefits</p> <p>SMM: Annual Enrollment for 2013 Benefits</p> <p>SMM: Annual Enrollment for 2014 Benefits</p>

Participating Program: TPA or Insurer/Benefit Option	Incorporated Program Documents
Long-Term Care Insurance (Metropolitan Life Insurance Company) (no new policies issued after August 1, 2011)	<p>MetLife Group Qualified Long-Term Care Policy</p> <p>MetLife Group Long-Term Care Insurance Policy #0122797-G</p> <p>MetLife LTC Outline of Coverage</p> <p>MetLife LTC Rider</p> <p>MetLife LTC Application</p> <p>Welfare Benefits Plan SPD</p> <p>SMMs: Quick Start 2009 Enrollment Guide and 2009 Benefit Plan Features and Rates</p> <p>SMM: Enrollment 2010 Quick Start Guide and Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 6/1/2010</p> <p>SMM: Benefits Central is Changing — 9/1/2010</p> <p>SMM: Annual Enrollment for 2011 Quick Start Guide Plan Features and Rates</p> <p>SMM: Discover Welfare Benefits Plan — 1/1/2011</p> <p>SMM: Annual Enrollment for 2012 Benefits</p> <p>SMM: Annual Enrollment for 2013 Benefits</p> <p>SMM: Annual Enrollment for 2014 Benefits</p>

Participating Program: TPA or Insurer/Benefit Option	Incorporated Program Documents
Legal Assistance Program (Hyatt Legal Plans)	Hyatt Legal Plan Renewal Agreement — 1/1/2011 Welfare Benefits Plan SPD SMMs: Quick Start 2009 Enrollment Guide and 2009 Benefit Plan Features and Rates SMM: Enrollment 2010 Quick Start Guide and Plan Features and Rates SMM: Discover Welfare Benefits Plan — 6/1/2010 SMM: Benefits Central is Changing — 9/1/2010 SMM: Annual Enrollment for 2011 Quick Start Guide Plan Features and Rates SMM: Discover Welfare Benefits Plan — 1/1/2011 SMM: Annual Enrollment for 2012 Benefits SMM: Annual Enrollment for 2013 Benefits SMM: Annual Enrollment for 2014 Benefits
Employee Assistance Program (Optum/United Behavioral Health)	Services Agreement with United Behavioral Health Welfare Benefits Plan SPD SMMs: Quick Start 2009 Enrollment Guide and 2009 Benefit Plan Features and Rates SMM: Enrollment 2010 Quick Start Guide and Plan Features and Rates SMM: Discover Welfare Benefits Plan — 6/1/2010 SMM: Benefits Central is Changing — 9/1/2010 SMM: Annual Enrollment for 2011 Quick Start Guide Plan Features and Rates SMM: Discover Welfare Benefits Plan — 1/1/2011 SMM: Annual Enrollment for 2012 Benefits SMM: Annual Enrollment for 2013 Benefits SMM: Annual Enrollment for 2014 Benefits
Severance Pay Program	Severance Pay Plan SPD
Change in Control Severance Policy	Change in Control Severance Policy

Participating Program: TPA or Insurer/Benefit Option	Incorporated Program Documents
Commuter Benefit Program (WageWorks)	Commuter Benefits Summary Welfare Benefits Plan SPD SMMs: Quick Start 2009 Enrollment Guide and 2009 Benefit Plan Features and Rates SMM: Enrollment 2010 Quick Start Guide and Plan Features and Rates SMM: Annual Enrollment for 2011 Quick Start Guide Plan Features and Rates SMM: Annual Enrollment for 2012 Benefits SMM: Annual Enrollment for 2013 Benefits SMM: Annual Enrollment for 2014 Benefits
Critical Illness (MetLife)	Critical Illness Insurance Disclosure Statement/Certificate of Coverage SMM: Annual Enrollment for 2014 Benefits

SUPPLEMENT B
PRE-TAX COMPONENT PROGRAMS

The Plan Administrator has designated the following Participating Programs to be treated as Pre-Tax Component Programs under the Plan:

1. Medical Participating Program
 - a. BCBS HRA
 - b. BCBS PPO
 - c. BCBS HSA
 - d. HMSA Medical Plan (for Hawaii employees)
 - e. SelectHealth HMO (for Utah employees)
 - f. Kaiser HMO (for California employees)
2. Dental Participating Program
 - a. Standard Option
 - b. Premier Option
3. Vision Participating Program
 - a. Standard Option
 - b. Premier Option
4. Flexible Spending Account Programs
 - a. Health Care Flexible Spending Account Program
 - b. Dependent Day Care Flexible Spending Account Program
 - c. Limited Purpose Health Care Flexible Spending Account Program

SUPPLEMENT C
PARTICIPATING EMPLOYERS

The following Participating Employers participate in the Plan:

Participating Employers	Effective Date of Participation in Plan
Discover Financial Services (Plan Sponsor)	July 1, 2007
Discover Bank	July 1, 2007
Discover Products Inc.	July 1, 2007
Pulse Network LLC	July 1, 2007
DFS Services LLC	July 1, 2007
DFS International Inc.	July 1, 2007
Diners Club International, Ltd.	October 1, 2008
The Student Loan Corporation	January 1, 2011
Discover Financial Services Insurance Agency, Inc.	July 1, 2007
DB Servicing Corporation	January 1, 2011
DFS Services LLC	January 1, 2011
Discover Corporate Services LLC	January 1, 2011
Discover Home Loans, Inc.	June 7, 2012
DFS Escrow, Inc.	June 7, 2012
HLC Settlement Services, Inc.	June 7, 2012

EXHIBIT K

Your Health Care Benefit Program



BRG Sports, Inc.
Premier Plan – 018640

Administered by:



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.™

ELIGIBILITY SECTION INSERT**All American Riddell**

018639, 018640, 018641, 015945

Coverage Date

The Coverage Date for a person who becomes an Eligible Person after the effective date of the Employer's Health Care Plan is the first day of the month following 30 days of employment for all employees except factory hourly employees. The Coverage Date for factory hourly employees is the first day of the month following 90 days of employment.

Effective Date of Termination

The effective date of termination is the end of the month in which the member ceases to meet the definition of an Eligible Person. All members are covered until midnight of the day the member no longer meets the definition of an Eligible Person.

BRG Sports, Inc.

018645, 018646, 015967, 018647, 018648

Coverage Date

The Coverage Date for a person who becomes an Eligible Person after the effective date of the Employer's Health Care Plan is the first day of the month following 30 days of employment for all employees.

Effective Date of Termination

The effective date of termination is the end of the month in which the member ceases to meet the definition of an Eligible Person. All members are covered until midnight of the day the member no longer meets the definition of an Eligible Person.

Riddell Sports

018642, 018643, 018644, 015946

Coverage Date

The Coverage Date for a person who becomes an Eligible Person after the effective date of the Employer's Health Care Plan is the first day of the month following 30 days of employment for all employees.

Effective Date of Termination

The effective date of termination is the end of the month in which the member ceases to meet the definition of an Eligible Person. All members are covered until midnight of the day the member no longer meets the definition of an Eligible Person.

ELIGIBILITY SECTION INSERT**BRG Sports, Inc.**

016063, 016064

Coverage Date

The Coverage Date for a person who becomes an Eligible Person after the effective date of the Employer's Health Care Plan is the first day of the month following 30 days of employment for all employees except York Union and factory hourly employees. The Coverage Date for York Union employees is the sixty-first(61st) day of the month following the first day of employment. The Coverage Date for factory hourly employees is the first day of the month following 90 days of employment.

Effective Date of Termination Except for York Union

The effective date of termination is the end of the month in which the member ceases to meet the definition of an Eligible Person. All members are covered until midnight of the day the member no longer meets the definition of an Eligible Person.

Effective Date of Termination for York Union

The effective date of termination is the date the member ceases to meet the definition of an Eligible Person. All members are covered until midnight of the day the member no longer meets the definition of an Eligible Person.

A message from

BRG Sports,Inc.

This booklet describes the Health Care Plan which we provide to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your health care claims, we have engaged Blue Cross and Blue Shield of Illinois as Claim Administrator.

Please read the information in this benefit booklet carefully so you will have a full understanding of your health care benefits. If you want more information or have any questions about your health care benefits, please contact the Employee Benefits Department.

Sincerely,

BRG Sports,Inc.

of 1230
NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those Providers.

Please refer to the provision entitled “Claim Administrator’s Separate Financial Arrangements with Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Please note that the Claim Administrator has contracts, either directly or indirectly, with many prescription drug providers that provide the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those providers.

Please refer to the provision entitled “Claim Administrator’s Separate Financial Arrangements with Prescription Drug Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Blue Cross and Blue Shield of Illinois provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

**WARNING, LIMITED BENEFITS WILL BE PAID WHEN
NON-PARTICIPATING PROVIDERS ARE USED**

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy’s fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the plan. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED UNDER THIS COVERAGE AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

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BENEFIT HIGHLIGHTS

Your health care benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire benefit booklet.

**THE UTILIZATION
REVIEW PROGRAM**

A special program designed to assist you in determining the course of treatment that will maximize your benefits under this benefit booklet

Lifetime Maximum
for all Benefits

Unlimited

Individual Deductible

- Participating Provider \$1,000 per benefit period
- Non-Participating and
Non-Administrator Provider \$4,000 per benefit period

Family Deductible

- Participating Provider \$3,000 per benefit period
- Non-Participating and
Non-Administrator Provider \$12,000 per benefit period

Individual Out-of-Pocket
Expense Limit

(does not apply to all services)

- Participating Provider \$2,500 per benefit period
- Non-Participating Provider \$7,500 per benefit period
- Non-Administrator Provider No limit

Family Out-of-Pocket
Expense Limit

- Participating Provider \$7,500 per benefit period
- Non-Participating Provider \$22,500 per benefit period
- Non-Administrator Provider No limit

Private Duty Nursing Service

Benefit Maximum 60 visits per benefit period

Chiropractic and Osteopathic

Manipulation Benefit Maximum 35 visits per benefit period

Naprapathic Services

Benefit Maximum \$1,000 per benefit period

Physical Therapy Services

Benefit Maximum 60 visits per benefit period

Occupational Therapy

Benefit Maximum 60 visits per benefit period

Speech Therapy

Benefit Maximum 60 visits per benefit period

HOSPITAL BENEFITS

Payment level for Covered
Services from a

Participating Provider:

- Inpatient Covered Services 80% of the Eligible Charge
- Outpatient Covered Services 80% of the Eligible Charge
- Urgent Care \$45 Copayment, then
100% of the Eligible Charge,
no deductible

Payment level for Covered
Services from a

Non-Participating Provider:

- Inpatient Covered Services 70% of the Eligible Charge
- Outpatient Covered Services 70% of the Eligible Charge

Payment level for Covered
Services from a

Non-Administrator Provider

50% of the Eligible Charge

Hospital Emergency Care

- Payment level for
Emergency Accident
Care from either a
Participating,
Non-Participating or
Non-Administrator Provider 100% of the Eligible Charge,
no deductible
- Payment level for
Emergency Medical
Care from either
a Participating,
Non-Participating or
Non-Administrator Provider 100% of the Eligible Charge,
no deductible

Emergency Room

\$200 Copayment
(waived if admitted to the Hospital
as an Inpatient immediately following
emergency treatment)

PHYSICIAN BENEFITS

Payment level for Surgical/
Medical Covered Services

- **Participating Provider** 80% of the Maximum Allowance
- **Non-Participating Provider** 70% of the Maximum Allowance

Payment level for
Covered Services received in a
Professional Provider's Office

- Participating Provider (other than a specialist) \$30 per visit, then 100% of the Maximum Allowance, no deductible
- Participating Provider Specialist \$45 per visit, then 100% of the Maximum Allowance, no deductible

Payment level for Emergency Accident Care 100% of the Maximum Allowance, no deductible

Payment level for Emergency Medical Care 100% of the Maximum Allowance, no deductible

OTHER COVERED SERVICES

Payment level 80% of the Eligible Charge or Maximum Allowance

PRESCRIPTION DRUG PROGRAM BENEFITS

Copayment

- generic drugs \$15 per prescription
- Formulary brand name drugs and all diabetic supplies \$40 per prescription
- non-Formulary brand name drugs \$60 per prescription
- self-injectable drugs other than insulin drugs \$60 per prescription

Home Delivery Prescription Drug Program

Copayment

- generic drugs \$25 per prescription
- Formulary brand name drugs and all diabetic supplies \$85 per prescription
- non-Formulary brand name drugs \$135 per prescription
- self-injectable drugs other than insulin and infertility drugs \$135 per prescription

TO IDENTIFY NON-ADMINISTRATOR AND ADMINISTRATOR HOSPITALS OR FACILITIES, YOU SHOULD CONTACT THE CLAIM ADMINISTRATOR BY CALLING THE CUSTOMER SER-

**VICE TOLL-FREE TELEPHONE NUMBER ON YOUR
IDENTIFICATION CARD.**

DEFINITIONS SECTION

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

ADMINISTRATOR PROGRAM.....means programs for which a Hospital has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time services are rendered to you. These programs are limited to a Partial Hospitalization Treatment Program or Coordinated Home Care Program.

ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

ADVANCED PRACTICE NURSE.....means Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist operating within the scope of his or her certification.

AMBULANCE TRANSPORTATION.....means local transportation in a specially equipped certified ground and air ambulance options from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.

AMBULANCE TRANSPORTATION ELIGIBLE CHARGE.....means the amount that represents the billed charges from the majority of the ambulance providers in the Chicago metro area, as submitted to the Claim Administrator.

AMBULATORY SURGICAL FACILITY.....means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

An "Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Ambulatory Surgical Facility” means an Ambulatory Surgical Facility which does not meet the definition of an Administrator Ambulatory Surgical Facility.

ANESTHESIA SERVICES.....means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them respectively.

APPROVED CLINICAL TRIAL.....means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the preventive, detection or treatment of cancer or other life-threatening disease or condition and is one of the following:

- (i) A federally funded or approved trial,
- (ii) A clinical trial conducted under an FDA experimental/investigational new drug application, or
- (iii) A drug that is exempt from the requirement of an FDA experimental/investigational new drug application.

AVERAGE DISCOUNT PERCENTAGE (“ADP”).....means a percentage discount determined by the Claim Administrator that will be applied to a Provider’s Eligible Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by the Claim Administrator to be relevant to the particular Claim. The ADP reflects the Claim Administrator’s reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect related costs. (See provisions of this benefit booklet regarding “Claim Administrator’s Separate Financial Arrangements with Providers.”) In determining the ADP applicable to a particular Claim, the Claim Administrator will take into account differences among Hospitals and other facilities, the Claim Administrator’s contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when your benefits under the Health Care Plan are secondary to Medicare and/or coverage under any other group program.

BEHAVIORAL HEALTH PRACTITIONER.....means a Physician or Professional Provider who is duly licensed to render services for Mental Illness, Serious Mental Illness or Substance Use Disorders and is operating within the scope of such license.

BILLED CHARGES.....means the total gross amounts billed by Providers to the Claim Administrator on a Claim, which constitutes the usual retail price

that the Provider utilizes to bill patients or any other party that may be responsible for payment of the services rendered without regard to any payor, discount or reimbursement arrangement that may be applicable to any particular patient. This list of retail prices is also sometimes described in the health care industry as a “chargemaster.”

CARE COORDINATION.....means organized, information-driven patient care activities intended to facilitate the appropriate responses to participant’s health care needs cross the continuum of care.

CARE COORDINATION FEE.....means a fixed amount paid by a Blue Cross and/or Blue Shield plan to Providers.

CERTIFIED CLINICAL NURSE SPECIALIST.....means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse and is operating within the scope of such license; and
- (ii) is a graduate of an advanced practice nursing program.

A “Participating Certified Clinical Nurse Specialist” means a Certified Clinical Nurse Specialist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Clinical Nurse Specialist” means a Certified Clinical Nurse Specialist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE-MIDWIFE.....means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse and is operating within the scope of such license; and
- (ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

A “Participating Certified Nurse-Midwife” means a Certified Nurse-Midwife who has a written agreement with the Claim Administrator or another

Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Nurse-Midwife” means a Certified Nurse-Midwife who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE PRACTITIONER.....means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse and is operating within the scope of such license; and
- (ii) is a graduate of an advanced practice nursing program.

A “Participating Certified Nurse Practitioner” means a Certified Nurse Practitioner who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Nurse Practitioner” means a Certified Nurse Practitioner who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED REGISTERED NURSE ANESTHETIST or CRNA.....means a nurse anesthetist who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse and is operating within the scope of such license; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

A “Participating Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CHEMOTHERAPY.....means the treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

CHIROPRACTOR.....means a duly licensed chiropractor and is operating within the scope of his or her license.

CIVIL UNION.....means a legal relationship between two persons, of either the same or opposite sex, established pursuant to or as otherwise recognized by the Illinois Religious Freedom Protection and Civil Union Act.

CLAIM.....means notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

CLAIM ADMINISTRATOR.....means Blue Cross and Blue Shield of Illinois.

CLAIM CHARGE.....means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding "The Claim Administrator's Separate Financial Arrangements with Providers.")

CLAIM PAYMENT.....means the benefit payment calculated by the Claim Administrator, after submission of a Claim, in accordance with the benefits described in this benefit booklet. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding "The Claim Administrator's Separate Financial Arrangements with Providers.")

CLINICAL LABORATORY.....means a clinical laboratory which complies with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, the Medicare and Medicaid programs and any applicable state and local statutes and regulations.

A "Participating Clinical Laboratory" means a Clinical Laboratory which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Laboratory" means a Clinical Laboratory which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan provide services to you at the time services are rendered.

CLINICAL PROFESSIONAL COUNSELOR.....means a duly licensed clinical professional counselor operating within the scope of his or her license.

A “Participating Clinical Professional Counselor” means a Clinical Professional Counselor who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Professional Counselor” means a Clinical Professional Counselor who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL SOCIAL WORKER.....means a duly licensed clinical social worker operating within the scope of his or her license.

A “Participating Clinical Social Worker” means a Clinical Social Worker who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Social Worker” means a Clinical Social Worker who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this program.

COINSURANCE.....means a percentage of an eligible expense that you are required to pay towards a Covered Service.

COMPLICATIONS OF PREGNANCY.....means all physical effects suffered as a result of pregnancy which would not be considered the effect of normal pregnancy.

COORDINATED HOME CARE PROGRAM.....means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital’s licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

An “Administrator Coordinated Home Care Program” means a Coordinated Home Care Program which has a written agreement with the Claim

Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time service is rendered to you.

A “Non-Administrator Coordinated Home Care Program” means a Coordinated Home Care Program which does not have an agreement with the Claim Administrator or a Blue Cross Plan but has been certified as a home health agency in accordance with the guidelines established by Medicare.

COPAYMENT.....means a specified dollar amount that you are required to pay towards a Covered Service.

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE.....means the date on which your coverage under the Health Care Plan begins.

COVERED SERVICE.....means a service and supply specified in this benefit booklet for which benefits will be provided.

CREDITABLE COVERAGE.....means coverage you had under any of the following:

- (i) A group health plan.
- (ii) Health insurance coverage for medical care under any hospital or medical service policy plan, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.
- (iii) Medicare (Parts A or B of Title XVIII of the Social Security Act).
- (iv) Medicaid (Title XIX of the Social Security Act).
- (v) Medical care for members and certain former members of the uniformed services and their dependents.
- (vi) A medical care program of the Indian Health Service or of a tribal organization.
- (vii) A State health benefits risk pool.
- (viii) A health plan offered under the Federal Employees Health Benefits Program.
- (ix) A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country.
- (x) A health plan under Section 5(e) of the Peace Corps Act.

- (xi) State Children's Health Insurance Program (Title XXI of the Social Security Act).

CUSTODIAL CARE SERVICE.....means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

DEDUCTIBLE.....means the amount of expense that you must incur in Covered Services before benefits are provided.

DENTIST.....means a duly licensed dentist operating within the scope of his or her license.

DIAGNOSTIC SERVICE.....means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-ray, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, electromyograms, magnetic resonance imaging (MRI), computed tomography (CT) scans and positron emission tomography (PET) scans.

DIALYSIS FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services, when operating within the scope of such license.

An "Administrator Dialysis Facility" means a Dialysis Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Dialysis Facility" means a Dialysis Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with the guidelines established by Medicare.

DOMESTIC PARTNER.....means a person with whom you have entered into a Domestic Partnership.

DOMESTIC PARTNERSHIP.....means long-term committed relationship of indefinite duration with a person of the same or opposite sex which meets the following criteria:

- (i) you and your Domestic Partner have lived together for at least 6 months,
- (ii) neither you nor your Domestic Partner is married to anyone else or has another Domestic Partner,
- (iii) your Domestic Partner is at least 18 years of age and mentally competent to consent to contract,
- (iv) your Domestic Partner resides with you and intends to do so indefinitely,
- (v) you and your Domestic Partner have an exclusive mutual commitment similar to marriage, and
- (vi) you and your Domestic Partner are not related by blood closer than would bar marriage in the state of your legal residence (i.e., the blood relationship is not one which would forbid marriage in the state of your residence, if you and the Domestic Partner were of the opposite sex).

You and your Domestic Partner must be jointly responsible for each other's common welfare and must share financial obligations. Joint responsibility may be demonstrated by the existence of at least 3 of the following: a signed Affidavit of Domestic Partnership, a joint mortgage or lease, designation of you or your Domestic Partner as a beneficiary in the other partner's life insurance and retirement contract, designation of you or your Domestic Partner as the primary beneficiary in your or your Domestic Partner's will, durable property and health care powers of attorney, or joint ownership of a motor vehicle, checking account or credit account.

DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider, when operating within the scope of such license.

A "Participating Durable Medical Equipment Provider" means a Durable Medical Equipment Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Durable Medical Equipment Provider" means a Durable Medical Equipment Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ELIGIBLE CHARGE (Effective January 1, 2017 or the Coverage Date of this benefit booklet, whichever is later, through November 30, 2017).....means (a) in the case of a Provider, other than a Professional Provider, which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are ren-

dered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider, other than a Professional Provider, which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, will be the lesser of (unless otherwise required by applicable law or arrangement with the Non-Participating Provider):

- (i) the Provider's billed charges, or;
- (ii) the Claim Administrator non-contracting Eligible Charge. Except as otherwise provided in this section, the non-contracting Eligible Charge is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Eligible Charge for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating or Non-Administrator Provider's standard billed charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined from the information submitted on the Claim, the Eligible Charge for Non-Participating or Non-Administrator Providers will be 50% of the Non-Participating or Non-Administrator Provider's standard billed charge for such Covered Service. (See provisions of this benefit booklet regarding "The Claim Administrator's Separate Financial Arrangements with Providers.")

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Provider Claims for processing Claims submitted by Non-Participating or Non-Administrator Providers which may also alter the Eligible Charge for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

ELIGIBLE CHARGE (Effective on and after December 1, 2017).....means (a) in the case of a Provider, other than a Professional Provider, which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to participants in the benefit program or is

designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider, other than a Professional Provider, which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to participants in the benefit program, or is not designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services are rendered, the following amount:

- (i) the lesser of (unless otherwise required by applicable law or arrangement with the Non-Participating Provider) (a) the Provider's Billed Charges, and (b) an amount determined by the Claim Administrator to be approximately 100% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim; or
- (ii) if there is no base Medicare reimbursement rate available for a particular Covered Service, or if the base Medicare reimbursement amount cannot otherwise be determined under subsection (i) above based upon the information submitted on the Claim, the lesser of (unless otherwise required by applicable law or arrangement with the Non-Participating Provider) (a) the Provider's Billed Charges and (b) an amount determined by the Claim Administrator to be 100% of the Maximum Allowance that would apply if the services were rendered by a Participating Professional Provider on the date of service; or
- (iii) if the base Medicare reimbursement amount and the Maximum Allowance cannot be determined under subsections (i) or (ii) above, based upon the information submitted on the Claim, then the amount will be 100% of the Provider's Billed Charges, provided, however, that the Claim Administrator may limit such amount to the lowest contracted rate that the Claim Administrator has with a Participating Provider for the same or similar services based upon the type of provider and the information submitted on the Claim, as of January 1 of the same year that the Covered Services are rendered to you.

In addition to the foregoing, the Eligible Charge will be subject in all respects to the Claim Administrator's Claim Payment rules, edit and methodologies regardless of the Provider's status as a Participating Provider or Non-Participating Provider. (See provisions of this benefit booklet regarding "The Claim Administrator's Separate Financial Arrangements with Providers.")

Notwithstanding the preceding sentence, the non-contracting Eligible Charge for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating or Non-Administrator Provider's standard billed charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined from the information submitted on the Claim, the Eligible Charge for Non-Participating or Non-Administrator Providers will be 50% of the Non-Participating or Non-Administrator Provider's standard billed charge for such Covered Service. (See provisions of this benefit booklet regarding "The Claim Administrator's Separate Financial Arrangements with Providers.")

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Provider Claims for processing Claims submitted by Non-Participating or Non-Administrator Providers which may also alter the Eligible Charge for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

ELIGIBLE PERSON.....means an employee of the Employer who meets the eligibility requirements for this health and/or dental coverage, as described in the **ELIGIBILITY SECTION** of this benefit booklet.

EMERGENCY ACCIDENT CARE.....means the initial Outpatient treatment of accidental injuries including related Diagnostic Services. The initial Outpatient treatment does not include surgical procedures, including but not limited to, stitching, gluing and casting.

EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (ii) serious impairment to bodily functions; or
- (iii) serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION.....means an admission for the treatment of Mental Illness or Substance Use Disorders as a result of the sudden and unexpected onset of a Mental Illness or Substance Use Disorder condition such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

EMPLOYER.....means the company with which you are employed.

ENROLLMENT DATE.....means the first day of coverage under your Employer's health plan or, if your Employer has a waiting period prior to the effective date of your coverage, the first day of the waiting period (typically, the date employment begins).

EXPERIMENTAL/INVESTIGATIONAL or EXPERIMENTAL/INVESTIGATIONAL SERVICES AND SUPPLIES.....means these of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as Standard Medical Treatment of the condition being treated for any of such items requiring Federal or other governmental agency approval not granted at the time services were provided. Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. As used herein, medical treatment includes medical, surgical, or dental treatment.

Standard Medical Treatment means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the Hospital or Facility Other Provider in which they were performed; and
- the Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of the Claim Administrator shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-fixed programs in making its determination.

Although a Physician or Professional Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort. The Claim Administrator still may determine such services or supplies

to be Experimental/Investigational with this definition. Treatment provided as part of a clinic trial or research study is Experimental/Investigational.

FAMILY COVERAGE.....means coverage for you and your eligible dependents under the Health Care Plan.

HOME INFUSION THERAPY PROVIDER.....means a duly licensed home infusion therapy provider, when operating within the scope of such license.

A “Participating Home Infusion Therapy Provider” means a Home Infusion Therapy Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Home Infusion Therapy Provider” means a Home Infusion Therapy Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

HOSPICE CARE PROGRAM PROVIDER.....means an organization duly licensed to provide Hospice Care Program Service, when operating within the scope of such license.

A “Participating Hospice Care Program Provider” means a Hospice Care Program Provider that either: (i) has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield to provide services to participants in this benefits program, or; (ii) a Hospice Care Program Provider which has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider Option program.

A “Non-Participating Hospice Care Program Provider” means a Hospice Care Program Provider that either: (i) does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield to provide services to participants in the, or; (ii) a Hospice Care Program Provider which has not been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider Option program.

HOSPICE CARE PROGRAM SERVICE.....means a centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility or special hospice care unit.

HOSPITAL.....means a facility which is a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses and which is either accredited by the Joint Commission on Accreditation of Hospitals or certified by the Social Security Administration as eligible for participation under Title XVIII, Health Insurance for the Aged and Disabled.

An “Administrator Hospital” means a Hospital which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Hospital” means a Hospital that does not meet the definition of an Administrator Hospital.

A “Participating Hospital” means an Administrator Hospital that has an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide Hospital services to participants in the Participating Provider Option program.

A “Non-Participating Hospital” means an Administrator Hospital that does not meet the definition of a Participating Hospital.

INDIVIDUAL COVERAGE.....means coverage under the Health Care Plan for yourself but not your spouse and/or dependents.

INFERTILITY.....means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to attain or maintain a viable pregnancy or sustain a successful pregnancy.

INFUSION THERAPY.....means the administration of medication through a needle or catheter. It is prescribed when a patient’s condition is so severe that it cannot be treated effectively by oral medications. Typically, “Infusion Therapy” means that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Infusion Therapy, in most cases, requires health care professional services for the safe and effective administration of the medication.

INPATIENT.....means that you are a registered bed patient and are treated as such in a health care facility.

LIFE-THREATENING DISEASE OR CONDITION.....means, for the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

LONG TERM CARE SERVICES.....means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury or condition.

MAINTENANCE CARE.....means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY.....means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

MARRIAGE AND FAMILY THERAPIST (“LMFT”).....means a duly licensed marriage and family therapist operating within the scope of his or her license.

A “Participating Marriage and Family Therapist” means a Marriage and Family Therapist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Marriage and Family Therapist” means a Marriage and Family Therapist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

MATERNITY SERVICE.....means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

MAXIMUM ALLOWANCE (Effective January 1, 2017 or the Coverage Date of this benefit booklet, whichever is later, through November 30, 2017).....means (a) the amount which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Professional Providers will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. (b) For Non-Participating Professional Providers, the Maximum Allowance will be the lesser of (unless otherwise required by applicable law or arrangement with Non-Participating Providers):

- (i) the Provider’s billed charges, or;
- (ii) the Claim Administrator non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Maximum Allowance for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating Professional Provider’s standard billed charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined from the information submitted on the Claim, the Maximum Allowance for Non-Participating Professional Providers will be 50% of the Non-Participating Professional Provider's standard billed charge for such Covered Service. (See provisions of this benefit booklet regarding "The Claim Administrator's Separate Financial Arrangements with Providers.")

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Professional Provider Claims for processing Claims submitted by Non-Participating Professional Providers which may also alter the Maximum Allowance for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

MAXIMUM ALLOWANCE (Effective on and after December 1, 2017).....means (a) the amount which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Professional Providers will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. (b) For Non-Participating Professional Providers, the Maximum Allowance will be the lesser of (unless otherwise required by applicable law or arrangement with the Non-Participating providers):

- (i) the Provider's billed charges, or;
- (ii) the Claim Administrator non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Maximum Allowance for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating Professional Provider's standard billed charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined from the information submitted on the Claim, the Maximum Allowance for Non-Participating Professional Providers will be 100% of the Claim Administrator's rate for such Covered Service according to its current Schedule of Maximum Allowance. If there is no rate according to the Schedule of Maximum Allowance, then the Maximum Allowance will be 25% of Billed Charges.

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Professional Provider Claims for processing Claims submitted by Non-Participating Professional Providers which may also alter the Maximum Allowance for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

MEDICAL CARE.....means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

MEDICALLY NECESSARY.....SEE EXCLUSIONS SECTION OF THIS BENEFIT BOOKLET.

MEDICARE.....means the program established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.).

MEDICARE APPROVED or MEDICARE PARTICIPATING.....means a Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

MEDICARE SECONDARY PAYER or MSP.....means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

MENTAL HEALTH UNIT.....means a unit established to assist in the administration of Mental Illness and Substance Use Disorder Rehabilitation Treatment benefits including Preauthorization, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for Inpatient Hospital admissions for the treatment of Mental Illness and Substance Use Disorders.

MENTAL ILLNESS.....means those illnesses classified as disorders in the current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

“Serious Mental Illness”.....means the following mental disorders as classified in the current *Diagnostic and Statistical Manual* published by the American Psychiatric Association:

- (i) Schizophrenia;
- (ii) Paranoid and other psychotic disorders;
- (iii) Bipolar disorders (hypomanic, manic, depressive and mixed);
- (iv) Major depressive disorders (single episode or recurrent);
- (v) Schizoaffective disorders (bipolar or depressive);
- (vi) Pervasive developmental disorders;
- (vii) Obsessive-compulsive disorders;
- (viii) Depression in childhood and adolescence;
- (ix) Panic disorder;
- (x) Post-traumatic stress disorders (acute, chronic, or with delayed onset); and
- (xi) Anorexia nervosa and bulimia nervosa.

NAPRAPATH.....means a duly licensed naprapath operating within the scope of his or her license.

NAPRAPATHIC SERVICES.....means the performance of naprapathic practice by a Naprapath which may legally be rendered by them.

NON-ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

OCCUPATIONAL THERAPIST.....means a duly licensed occupational therapist operating within the scope of his or her license.

OCCUPATIONAL THERAPY.....means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

OPTOMETRIST.....means a duly licensed optometrist operating within the scope of his or her license.

A “Participating Optometrist” means an Optometrist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Optometrist” means an Optometrist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ORTHOTIC PROVIDER.....means a duly licensed orthotic provider operating within the scope of his or her license.

A “Participating Orthotic Provider” means an Orthotic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Orthotic Provider” means an Orthotic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PARTIAL HOSPITALIZATION TREATMENT PROGRAM.....means a Claim Administrator approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Rehabilitation Treatment in which patients spend days or nights.

PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

PARTICIPATING PRESCRIPTION DRUG PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER OPTION.....means a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

PHARMACY.....means any licensed establishment in which the profession of pharmacy is practiced.

PHYSICAL THERAPIST.....means a duly licensed physical therapist operating within the scope of his or her license.

PHYSICAL THERAPY.....means the treatment of a disease, injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches operating within the scope of his or her license.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider operating within the scope of his or her license.

PODIATRIST.....means a duly licensed podiatrist operating within the scope of his or her license.

PREAUTHORIZATION, PREAUTHORIZE or EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION REVIEW.....means a submission of a request to the Mental Health Unit for a determination of Medically Necessary care under this benefit booklet.

PRIVATE DUTY NURSING SERVICE.....means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PROSTHETIC PROVIDER.....means a duly licensed prosthetic provider operating within the scope of his or her license.

A “Participating Prosthetic Provider” means a Prosthetic Provider who has a written agreement with the Claim Administrator or another Blue Cross

and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Prosthetic Provider” means a Prosthetic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you, and operating within the scope of such license.

An “Administrator Provider” means a Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Provider” means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.

A “Participating Provider” means an Administrator Hospital or Professional Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or an Administrator facility which has been designated by the Claim Administrator as a Participating Provider.

A “Non-Participating Provider” means an Administrator Hospital or Professional Provider which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or a facility which has not been designated by the Claim Administrator as a Participating Provider.

A “Professional Provider” means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist or any Provider designated by the Claim Administrator or another Blue Cross and/or Blue Shield Plan.

A “Participating Prescription Drug Provider” means a Pharmacy that has a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer its prescription drug program to provide services to you at the time you receive the services.

PROVIDER INCENTIVE.....means an additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider’s compliance with agreed upon procedural and/or outcome measures for a particular population of participants.

PSYCHOLOGIST.....means a Registered Clinical Psychologist operating within the scope of such license.

Registered Clinical Psychologist means a Clinical Psychologist who is registered with the Illinois Department of Financial and Professional Regulation pursuant to the Illinois “Psychologists Registration Act” or, in a state where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program; or

is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

REGISTERED SURGICAL ASSISTANT.....means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant operating within the scope of his or her certification.

A “Participating Registered Surgical Assistant” means a Registered Surgical Assistant who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Registered Surgical Assistant” means a Registered Surgical Assistant who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

RENAL DIALYSIS TREATMENT.....means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

RESIDENTIAL TREATMENT CENTER.....means a facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include halfway houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored

with 24 hour medical availability and 24 hour onsite nursing service for patients with Mental Illness and/or Substance Use Disorders. Requirements: the Claim Administrator requires that any Mental Illness and/or Substance Use Disorder Residential Treatment Center must be licensed in the state where it is located, or accredited by a national organization that is recognized by the Claim Administrator as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

RESPIRE CARE SERVICE.....means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services to you.

RETAIL HEALTH CLINIC.....means a health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by Certified Nurse Practitioners.

A “Participating Retail Health Clinic” means a Retail Health Clinic which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Retail Health Clinic” means a Retail Health Clinic which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ROUTINE PATIENT COSTS.....means the cost for all items and services consistent with the coverage provided under this benefit booklet that is typically covered for you if you are not enrolled in a clinical trial. Routine Patient Costs do not include:

- (i) The investigational item, device, or service, itself;
- (ii) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- (iii) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

SKILLED NURSING FACILITY.....means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services, and operating within the scope of such license.

An “Administrator Skilled Nursing Facility” means a Skilled Nursing Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Skilled Nursing Facility” means a Skilled Nursing Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with guidelines established by Medicare.

An “Uncertified Skilled Nursing Facility” means a Skilled Nursing Facility which does not meet the definition of an Administrator Skilled Nursing Facility and has not been certified in accordance with the guidelines established by Medicare.

SKILLED NURSING SERVICE.....means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

SPEECH THERAPIST.....means a duly licensed speech therapist operating within the scope of his or her license.

SPEECH THERAPY.....means the treatment for the correction of a speech impairment resulting from disease, including pervasive developmental disorders, trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

SUBSTANCE USE DISORDER.....means chemical dependency and/or the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Behavioral Health Practitioner, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

SUBSTANCE USE DISORDER TREATMENT FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment of Substance Use Disorders and is licensed by the appropriate state and local authority to provide such service, when operating within the scope of such

license. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

An “Administrator Substance Use Disorder Treatment Facility” means a Substance Use Disorder Treatment Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Substance Use Disorder Treatment Facility” means a Substance Use Disorder Treatment Facility that does not meet the definition of an Administrator Substance Use Disorder Treatment Facility.

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claim Administrator.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

TOBACCO USER.....means a person who is permitted under state and federal law to legally use Tobacco, with Tobacco use (other than religious or ceremonial use of Tobacco), occurring on average four or more times per week that last occurred within the past six months (or such other meaning required or permitted by applicable law). Tobacco includes, but is not limited to, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, etc. For additional information, please call the number on the back of your identification card or visit our Website at www.bcbsil.com.

TOTALLY DISABLED.....means with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

TRANSPLANT LODGING ELIGIBLE EXPENSE.....means the amount of \$50 per person per day reimbursed for lodging expenses related to a covered transplant.

VALUE BASED PROGRAM.....means an out-come based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

ELIGIBILITY SECTION

This benefit booklet contains information about the health care benefit program for the persons who:

- Meet the definition of an Eligible Person as determined by your Employer;
- Have applied for this coverage; and
- Have received an identification card.

If you meet this description of an Eligible Person, you are entitled to the benefits of this program.

MEDICARE ELIGIBLE COVERED PERSONS

If you meet the definition of an Eligible Person stated in the ELIGIBILITY Section above and you are eligible for Medicare and not affected by the “Medicare Secondary Payer” (MSP) laws as described below, the benefits described in the section of this benefit booklet entitled “Benefits for Medicare Eligible Covered Persons” will apply to you and to your spouse and covered dependent children (if he or she is also eligible for Medicare and not affected by the MSP laws). This section does not apply to a party of a Civil Union with the Eligible Person and their children. This section does not apply to a Domestic Partner of the Eligible Person and their children.

A series of federal laws collectively referred to as the “Medicare Secondary Payer” (MSP) laws regulate the manner in which certain employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, dependent children.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer group health plan (“GHP”) coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

1. GHPs that cover individuals with end-stage renal disease (“ESRD”) during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has “current employment status.”
2. In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual’s spouse (of any age) has “current employment status.” If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).
3. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual’s family has “current employee status.” If the GHP is a multi-employer or multiple employer plan, which has at least one parti-

cipating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

PLEASE NOTE: SEE YOUR EMPLOYER OR GROUP ADMINISTRATOR SHOULD YOU HAVE ANY QUESTIONS REGARDING THE ESRD PRIMARY PERIOD OR OTHER PROVISIONS OF MSP LAWS AND THEIR APPLICATION TO YOU, YOUR SPOUSE OR ANY DEPENDENTS.

YOUR MSP RESPONSIBILITIES

In order to assist your employer in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from the Claim Administrator and/or your employer regarding the Medicare eligibility of you, your spouse and covered dependent children. In addition, if you, your spouse or covered dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact your employer or your group administrator promptly to ensure that your Claims are processed in accordance with applicable MSP laws.

YOUR ID CARD

You will receive an identification card. This card will tell you your identification number and will be very important to you in obtaining your benefits.

INDIVIDUAL COVERAGE

If you have Individual Coverage, only your own expenses for Covered Services are covered, not the expenses of other members of your family.

FAMILY COVERAGE

Child(ren) used hereafter, means a natural child(ren), a stepchild(ren), an adopted child(ren) who is in your custody under an interim court order of adoption or who is placed with you for adoption vesting temporary care.

If you have Family Coverage, your health expenses for Covered Services and those of your enrolled spouse and your (or your spouse's) enrolled children up to age 26 will be covered. All of the provisions of this benefit booklet that pertain to a spouse also apply to a party of a Civil Union unless specifically noted otherwise. The coverage for children will end on the last day of the month in which the limiting age is reached.

Your enrolled Domestic Partner and his or her enrolled children who have not attained the limiting age stated above will be covered. Whenever the term "spouse" is used, we also mean Domestic Partner. All of the provisions of this benefit booklet that pertain to a spouse also apply to a Domestic Partner, unless specifically noted otherwise.

Any newborn children will be covered from the moment of birth. Please notify your Group Administrator within 31 days of the date of birth so that your membership records can be adjusted.

Any children who are incapable of self-sustaining employment and are dependent upon you or other care providers for lifetime care and supervision because of a handicapped condition occurring prior to reaching the limiting age will be covered regardless of age if they were covered prior to reaching the limiting age stated above.

Any children who are under your legal guardianship or who are in your custody under an interim court order of adoption or who are placed with you for adoption vesting temporary care will be covered.

This coverage does not include benefits for grandchildren (unless such children are under your legal guardianship) or foster children.

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE OR ADDING DEPENDENTS TO FAMILY COVERAGE

You can change from Individual to Family Coverage or add dependents to your Family Coverage because of any of the following events:

- Marriage.
- Establishment of a Domestic Partnership.
- Becoming party to a Civil Union.
- Birth, adoption or placement for adoption of a child.
- Obtaining legal guardianship of a child.
- Loss of eligibility for other health coverage for you or your dependent if:
 - a. The other coverage was in effect when you were first eligible to enroll for this coverage;
 - b. The other coverage is not terminating for cause (such as failure to pay premiums or making a fraudulent claim); and
 - c. Where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment in this coverage.

This includes, but is not limited to, loss of coverage due to:

- a. Legal separation, divorce, dissolution from a civil union, cessation of dependent status, death of an employee, termination of employment, or reduction in the number of hours of employment;
- b. In the case of HMO, coverage is no longer provided because an individual no longer resides in the service area or the HMO no longer offers coverage in the HMO service area in which the individual resides;
- c. Reaching a lifetime limit on all benefits in another group health plan;
- d. Another group health plan no longer offering any benefits to the class of similarly situated individuals that includes you or your dependent;

- e. When Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
 - f. When you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.
- Termination of employer contributions towards your or your dependent's other coverage.
 - Exhaustion of COBRA continuation coverage or state continuation coverage.

When Coverage Begins

Your Family Coverage or the coverage for your additional dependents will be effective from the date of the event if you apply for this change within 31 days of any of the following events:

- Marriage.
- Establishment of a Domestic Partnership.
- Becoming party to a Civil Union.
- Birth, adoption, or placement of adoption of a child.
- Obtaining legal guardianship of a child.

Your Family Coverage or the coverage for your additional dependents will be effective from the date you apply for coverage if you apply within 31 days of any of the following events:

- Loss of eligibility for other coverage for you or your dependent, except for loss of coverage due to reaching a lifetime limit on all benefits.
- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

If coverage is lost in another group health plan because a lifetime limit on all benefits is reached under that coverage and you apply for Family Coverage or to add dependents within 31 days after a claim is denied due to reaching the lifetime limit, your Family Coverage or the coverage for your additional dependents will be effective from the date your claim was denied.

Your Family Coverage or the coverage for your additional dependents will be effective from the date of the event if you apply for this change within 60 days of any of the following events:

- Loss of eligibility for you or your dependents when Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or
- You or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You must request this special enrollment within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium

assistance under Medicaid or CHIP is determined. Coverage will be effective no later than the first of the month after the special enrollment request is received.

Late Applicants

If you do not apply for Family Coverage or to add dependents within the required number of days of the event, you will have to wait until your Employer's annual open enrollment period to make those changes. Such changes will be effective on a date that has been mutually agreed to by your Employer and the Claim Administrator.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

Should you wish to change from Family to Individual Coverage, you may do this at any time. Your Group Administrator will provide you with the application and tell you the date that the change will be effective.

TERMINATION OF COVERAGE

You will no longer be entitled to the benefits described in this benefit booklet if either of the events stated below should occur.

1. If you no longer meet the previously stated description of an Eligible Person.
2. If the entire coverage of your Employer terminates.
3. The date your severance package ends and COBRA rights start.

A person meets the criteria of (1) and (2) above while he is on a paid or unpaid leave of absence, for up to six months. Such extension of coverage, shall not count against any applicable COBRA continuation coverage. Further, termination of the agreement between the Claim Administrator and the Employer automatically terminates your coverage as described in this benefit booklet. It is the responsibility of the Employer to notify you in the event the agreement is terminated with the Claim Administrator. Regardless of whether such notice is provided, your coverage will terminate as of the effective date of termination of the Employer's agreement with the Claim Administrator.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under the Health Care Plan described in this benefit booklet except as otherwise specifically stated in the "Extension of Benefits in Case of Termination" provisions of this benefit booklet. However, termination of the Employer agreement with the Claim Administrator and/or termination of your coverage under the Health Care Plan shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this benefit booklet, if one of your dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible.

Other options available for Continuation of Coverage are explained in the COBRA Section of this benefit booklet.

UTILIZATION REVIEW PROGRAM

The Claim Administrator has established the Utilization Review Program to assist you in determining the course of treatment that will maximize your benefits under this Health Care Plan. The Utilization Review Program requires a review of Inpatient Hospital Covered Services **before** such services are rendered.

You are responsible for satisfying Preadmission/Admission Review requirements. This means that you must ensure that you, your family member, or Provider of services must comply with the guidelines below. Failure to obtain Preadmission/Admission Review for services will require additional steps and/or benefit reductions as described in the provision entitled FAILURE TO NOTIFY. The toll-free telephone number for Preadmission/Admission Review is on your ID card. Please read the provisions below very carefully.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever a nonemergency or nonmaternity Inpatient Hospital admission is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the Hospital admission.

If the proposed Hospital admission or health care services are determined to be not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised verbally of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. These letters may not be received prior to your scheduled date of admission.

- **Emergency Admission Review**

Emergency admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

In the event of an emergency admission, in order to receive maximum benefits under this benefit booklet, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

- **Pregnancy/Maternity Admission Review**

Pregnancy/Maternity admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Health Care Plan.

In the event of a maternity admission, in order to receive maximum benefits under this benefit booklet, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

Even though you are not required to call the Claim Administrator prior to your maternity admission, if you call the medical pre-notification number as soon as you find out you are pregnant, the Claim Administrator will provide you information on support programs to assist you during pregnancy.

CASE MANAGEMENT

Case management is a collaborative process that assists you with the coordination of complex care services. A Claim Administrator case manager is available to you as an advocate for cost-effective interventions.

Case managers are also available to you to provide assistance when you need alternative benefits. Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost-effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Health Care Plan.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Upon completion of the preadmission or emergency review, the Claim Administrator will send a letter to your Physician and/or the Hospital confirming that you or your representative called the Claim Administrator and that an approved length of service or length of stay was assigned.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. In the event that the extension is determined not to be Medically Necessary, the authorization will not be extended. Additional notification will be provided to your Physician and/or the Hospital regarding the denial of payment for the extension.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the Claim Administrator. The Claim Administrator will provide notification of a decision to not authorize payment for Inpatient care or other health care services or supplies to you, your Physician, and/or the Hospital or other Provider. The notification will specify the dates, services and/or supplies that are not considered Covered Services. For further details regarding Medically Necessary care and other exclusions from coverage, see the EXCLUSIONS—WHAT IS NOT COVERED section in this benefit booklet.

The Claim Administrator does not determine your course of treatment or whether you receive particular health care services. Decisions regarding the course of treatment and receipt of particular health care services are a matter entirely between you and your Physician. The Claim Administrator's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is a Covered Service under the Health Care Plan.

In the event that the Claim Administrator determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service charge incurred.

Remember that the Claim Administrator's Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not determined to be Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as medically necessary, the Claim Administrator will not pay for the hospitalization, services or supplies unless the Claim Administrator determines it to be Medically Necessary and a Covered Service under the Health Care Plan.

NOTE: Keep in mind that a Medically Necessary determination does not guarantee that benefits are available. For example, it might be determined that a service is Medically Necessary, however, the Health Care Plan may limit or exclude that service. In that case, the Medically Necessary determination does not override the benefit provision in the benefit booklet.

UTILIZATION REVIEW PROCEDURE

The following information is required when you contact the Claim Administrator:

1. The name of the attending and/or admitting Physician;

2. The name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;
3. The scheduled admission and/or service date; and
4. A preliminary diagnosis or reason for the admission and/or service.

Upon receipt of the required information, the Claim Administrator:

1. will review the information provided and seek additional information as necessary.
2. will issue a determination that the services are either Medically Necessary or are not Medically Necessary.
3. will provide notification of the determination.

APPEAL PROCEDURE

If you or your Physician disagree with the determination of the Claim Administrator prior to or while receiving services, you may appeal that decision. You should call the Claim Administrator's customer service number on your identification card. Your Physician should use the contact information in the notification letter.

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Medical Director
Health Care Service Corporation
P. O. Box A3957
Chicago, Illinois 60601

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Claim Administrator will not interfere with your relationship with any Provider. However, the Claim Administrator has established the Utilization Review Program for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits provided under this benefit booklet.

Should you fail to notify the Claim Administrator as required in the Preadmission Review provision of this section, you will then be responsible for the first \$500 of the Hospital or facility charges for an eligible stay or \$500 of the charges for eligible Covered Services for Private Duty Nursing in addition to any deductibles, Copayments and/or Coinsurance applicable to this benefit booklet. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this benefit booklet nor can it be applied to your out-of-pocket expense limit, if applicable, as described in this benefit booklet.

MEDICARE ELIGIBLE MEMBERS

The preadmission review provisions of this Utilization Review Program do not apply to you if you are Medicare eligible and have secondary coverage provided under the Health Care Plan.

CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT

The Claim Administrator's Mental Health Unit has been established to perform preadmission review and length of stay review for your Inpatient Hospital services for the treatment of Mental Illness and Substance Use Disorder. The Mental Health Unit is staffed primarily by Physicians, Psychologists, and registered nurses.

Failure to contact the Mental Health Unit or to comply with the determinations of the Mental Health Unit may result in a reduction of benefits. The Mental Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Behavioral Health Practitioner or Provider of services must comply with the guidelines below. Failure to Preauthorize services will require additional steps and/or benefit reductions as described in the provision entitled FAILURE TO PREAUTHORIZE OR NOTIFY.

PREAUTHORIZATION REVIEW

- **Inpatient Hospital Preauthorization Review**

Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

In order to receive maximum benefits under this Health Care Plan, you must Preauthorize your nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Use Disorder by calling the Mental Health Unit. Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the Inpatient Hospital admission.

- **Residential Treatment Center Preauthorization Review**

Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Health Care Plan.

Whenever an admission to a Residential Treatment Center for the treatment of Mental Illness or Substance Use Disorder is recommended by your physician, you must, in order to receive maximum benefits under this Health Care Plan, call the Mental Health Unit. This call must be made at least one day prior to scheduling of the admission. Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the Inpatient Hospital admission.

- **Emergency Mental Illness or Substance Use Disorder Admission Review**

Emergency Mental Illness or Substance Use Disorder Admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

In order to receive maximum benefits under this Health Care Plan, you or someone who calls on your behalf must notify the Mental Health Unit no later than two business days or as soon as reasonably possible after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits. Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

- **Partial Hospitalization Treatment Program Review**

Partial Hospitalization Treatment Program review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

In order to receive maximum benefits under this Health Care Plan, you must notify the Mental Health Unit no later than 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. Participating and Non-Participating Providers may call for you, when required, but it is your responsibility to ensure these requirements are satisfied. This call must be made at least 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. The Mental Health Unit will obtain information regarding the service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

If an Inpatient Emergency Mental Illness or Substance Use Disorder Admission occurs after a service(s), in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Mental Health Unit for an Emergency Mental Illness or Substance Use Disorder Admission Review.

- **Length of Stay/Service Review**

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Upon completion of the Preauthorization or Emergency Mental Illness or Substance Use Disorder Review, the Mental Health Unit will send you a letter confirming that you or your representative called the Mental Health Unit. A letter assigning a length of service or length of stay will be sent to your Behavioral Health Practitioner and/or the Hospital.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by the Mental Health Unit. In the event that the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to a Mental Health Unit Physician for review.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient Hospital admission, or other health care services or supplies are not Medically Necessary, as such term is defined in this benefit booklet, will be determined by the Mental Health Unit. If the Mental Health Unit Physician concurs that the Inpatient Hospital admission or other health care service or supply does not meet the criteria for Medically Necessary care, some days, services or the entire hospitalization will be denied. Your Behavioral Health Practitioner and in the case of an Inpatient Hospital admissions, the Hospital will be advised by telephone of this determinations, with a follow-up notification letter sent to you, your Behavioral Health Practitioner and the Hospital, and will specify the dates, services or supplies that are not considered Medically Necessary. The Mental Health Unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission or service. For further details regarding Medically Necessary care and other exclusions described in this benefit booklet, see the provision entitled, "EXCLUSIONS—WHAT IS NOT COVERED."

The Mental Health Unit does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Behavioral Health Practitioner. The Mental Health Unit's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization, or other health care service is Medically Necessary under the Health Care Plan.

In the event that the Mental Health Unit determines that all or any portion of an Inpatient Hospital admission, or other health care service or supply is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service or supply charge incurred.

Remember that your Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Behavioral Health Practitioner or another health care Provider may prescribe, order, recommend or approve an Inpatient Hospital admission, or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Behavioral Health Practitioner prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the Mental Health Unit Physician decides they were not Medically Necessary.

MENTAL HEALTH UNIT PROCEDURE

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission, and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review you should be prepared to provide the following information:

1. the name of the attending and/or admitting Behavioral Health Practitioner;
2. the name of the Hospital or facility where the admission and/or service has been scheduled, when applicable;
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission, and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review, the Mental Health Unit:

1. will review the medical information provided and follow-up with the Behavioral Health Practitioner;
2. upon request, will advise you of Participating Providers in the area who may be able to provide the admission and/or services that are the subject of the Preauthorization Review;
3. may determine that the admission and/or services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

Expedited Appeal

If you or your Behavioral Health Practitioner disagrees with the determinations of the Mental Health Unit prior to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Mental Health Unit and requesting an expedited appeal. The Mental Health Unit Physician will review your case and determine whether the service was Medically Necessary. You and/or your Behavioral Health Practitioner will be notified of the Mental Health Unit Physician's determination within twenty-four (24) hours or no later than the last authorized day. If you or your Behavioral Health Practitioner still disagree with the Mental Health Unit Physician, you may request an appeal in writing as outlined below.

Written Appeal

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after Claim processing has taken place or upon receipt of the notification letter from the Mental

Health Unit, you may appeal that decision by having your Behavioral Health Practitioner call the contact person indicated in the notification letter or by submitting a written request to:

Blue Cross and Blue Shield of Illinois
Appeals Coordinator
Blue Cross and Blue Shield BH Unit
P. O. Box 660240
Dallas, Texas 75266-0240
Fax Number: 1-877-361-7656

You must exercise the right to this appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to the Claim Administrator as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may review any relevant documents held by the Claim Administrator, if you request an appointment in writing.

Within 30 days of receiving your request for review, the Claim Administrator will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO PREAUTHORIZE OR NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Mental Health Unit will not interfere with your relationship with any Behavioral Health Practitioner. However, the Mental Health Unit has been established for the specific purpose of assisting you in maximizing your benefits as described in this benefit booklet.

Should you fail to Preauthorize or notify the Mental Health Unit as required in the Preauthorization Review provision of this section, you will then be responsible for the first \$500 of the Hospital charges for an eligible Hospital stay in addition to any deductibles, Copayments and/or Coinsurance applicable to this benefit booklet. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this benefit booklet nor can it be applied to your out-of-pocket expense limit, if applicable to this benefit booklet.

INDIVIDUAL BENEFITS MANAGEMENT PROGRAM ("IBMP")

In addition to the benefits described in this benefit booklet, if your condition would otherwise require continued care in a Hospital or other health care facility, provision of alternative benefits for services rendered by a Participating Provider in accordance with an alternative treatment plan may be available to you.

Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations or exclusions of the Health Care Plan.

MEDICARE ELIGIBLE MEMBERS

The provisions of the CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT section do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Health Care Plan.

THE PARTICIPATING PROVIDER OPTION

Your Employer has chosen the Claim Administrator's "Participating Provider Option" for the administration of your Hospital and Physician benefits. The Participating Provider Option is a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

As a participant in the Participating Provider Option a directory of Participating Providers is available to you. You can visit the Blue Cross and Blue Shield of Illinois Web site at www.bcbsil.com for a list of Participating Providers. While there may be changes in the directory from time to time, selection of Participating Providers by the Claim Administrator will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided to your Employer annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Provider.

Before reading the description of your benefits, you should understand the terms "Benefit Period" and "Deductible" as defined below.

YOUR BENEFIT PERIOD

Your benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first December 31st following that date.

YOUR DEDUCTIBLE

Each benefit period you must satisfy a \$1,000 deductible for Covered Services rendered by Participating Provider(s) and a separate \$4,000 deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Administrator Provider(s). In other words, after you have claims for Covered Services for more than the deductible amount in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.

FAMILY DEDUCTIBLE

If you have Family Coverage and your family has reached the program deductible amount of \$3,000 for Covered Services rendered by Participating Provider(s) and a separate \$12,000 program deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Administrator Provider(s), it will not be necessary for anyone else in your family to meet the program deductible in that benefit period. That is, for the remainder of that benefit period only, no other family member(s) is required to meet the program deductible before receiving benefits. A family member may not apply more than the individual program deductible amount toward the family program deductible.

In any case, should two or more members of your family ever receive Covered Services as a result of injuries received in the same accident, only one program deductible will be applied against those Covered Services.

HOSPITAL BENEFIT SECTION

Expenses for Hospital care are usually the biggest of all health care costs. Your Hospital benefits will help ease the financial burden of these expensive services. This section of your benefit booklet tells you what Hospital services are covered and how much will be paid for each of these services.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

The level of benefits paid for Hospital Covered Services is generally greater when received in an Administrator Hospital or other Administrator facility.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

INPATIENT CARE

The following are Covered Services when you receive them as an Inpatient in a Hospital.

Inpatient Covered Services

1. Bed, board and general nursing care when you are in:
 - a semi-private room
 - a private room
 - an intensive care unit
2. Ancillary services (such as operating rooms, drugs, surgical dressings and lab work)

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery.

These tests are considered part of your Inpatient Hospital surgical stay.

Partial Hospitalization Treatment

Benefits are available for this program only if it is an Administrator Program. No benefits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by the Claim Administrator.

Coordinated Home Care

Benefits will be provided for services under a Coordinated Home Care Program.

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

Participating Provider

When you receive Inpatient Covered Services from a Participating Provider or in an Administrator Program of a Participating Provider, benefits will be provided at 80% of the Eligible Charge after you have met your program deductible, unless otherwise specified in this benefit booklet. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Participating Provider

When you receive Inpatient Covered Services from a Non-Participating Provider or in an Administrator Program of a Non-Participating Provider, benefits will be provided at 70% of the Eligible Charge, after you have met your program deductible. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Administrator Provider

When you receive Inpatient Covered Services from a Non-Administrator Provider, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible.

Benefits for an Inpatient Hospital admission to a Non-Administrator or Non-Participating Provider resulting from Emergency Accident Care or Emergency Medical Care will be provided at the same payment level which you would have received had you been in a Participating Hospital for that portion of your Inpatient Hospital stay during which your condition is reasonably determined by the Claim Administrator to be serious and therefore not permitting your safe transfer to a Participating Hospital or other Participating Provider.

Benefits for an Inpatient Hospital admission to a Non-Administrator or Non-Participating Hospital resulting from Emergency Accident Care or Emergency Medical Care will be provided at the Non-Participating Hospital payment level or the Non-Administrator Hospital payment level (depending on the type of Provider) for that portion of your Inpatient Hospital stay during which your condition is reasonably determined by the Claim Administrator as not being serious and therefore permitting your safe transfer to a Participating Hospital or other Participating Provider.

In order for you to continue to receive benefits at the Participating Provider payment level following an emergency admission to a Non-Administrator or Non-Participating Hospital, you must transfer to a Participating Provider as soon as your condition is no longer serious.

OUTPATIENT HOSPITAL CARE

The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services

1. Surgery and any related Diagnostic Service received on the same day as the Surgery
2. Radiation Therapy Treatments
3. Chemotherapy
4. Electroconvulsive Therapy
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care
7. Urgent Care
8. Emergency Accident Care
9. Emergency Medical Care
10. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis
11. Approved Clinical Trials—Benefits for Covered Services for Routine Patient Costs are provided in connection with a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

Participating Provider

Benefits will be provided at 80% of the Eligible Charge after you have met your program deductible when you receive Outpatient Hospital Covered Services from a Participating Provider.

Benefits for urgent care from a Participating Provider will be provided at 100% of the Hospital's Eligible Charge, subject to a Copayment of \$45 per visit. Your program deductible will not apply.

Non-Participating Provider

When you receive Outpatient Hospital Covered Services from a Non-Participating Provider, benefits will be provided at 70% of the Eligible Charge after you have met your program deductible.

Non-Administrator Provider

When you receive Outpatient Hospital Covered Services from a Non-Administrator Provider, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible. Covered Services received for Emergency Accident Care and Emergency Medical Care from a Non-Administrator Provider will be paid at the same payment level which would have been paid had such services been received from a Participating Provider.

Emergency Care

Benefits for Emergency Accident Care will be provided at 100% of the Eligible Charge when you receive Covered Services from either a Participating, Non-Participating or Non-Administrator Provider. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the Emergency Accident Care payment level. Such services will be provided at the benefit payment level for Surgery described in this benefit booklet.

Benefits for Non-PPO emergency room physicians will be provided at the PPO benefit level if Covered Services for Emergency Accident Care are rendered in a PPO facility.

Benefits for Emergency Accident Care will not be subject to the program deductible.

Benefits for Emergency Medical Care will be provided at 100% of the Eligible Charge when you receive Covered Services from either a Participating, Non-Participating or Non-Administrator Provider.

Benefits for Emergency Medical Care will not be subject to the program deductible.

Benefits for Non-PPO emergency room physicians will be provided at the PPO benefit level if Covered Services for Emergency Medical Care are rendered in a PPO facility.

Each time you receive Covered Services in an emergency room, you will be responsible for a Copayment of \$200. If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room Copayment will be waived.

However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge whether or not you have met your program deductible. The emergency room Copayment will not apply.

Notwithstanding anything in this benefit booklet to the contrary, the method used to determine the Eligible Charge for Emergency care services will be equal to the greatest of the following three possible amounts:

1. the amount negotiated with Participating Providers for emergency care benefits furnished; or
2. the amount for the emergency care service calculated using the same method the Participating Providers generally uses to determine payments for Non-Participating Provider services but substituting the

Participating cost sharing provisions for the Non-Participating Provider cost-sharing provisions; or

3. the amount that would be paid under Medicare for the emergency care service.

Each of these three amounts is calculated excluding any Non-Participating Provider Copayment or Coinsurance imposed with respect to the covered person.

**WHEN SERVICES ARE NOT AVAILABLE FROM
A PARTICIPATING PROVIDER (HOSPITAL)**

If you must receive Hospital Covered Services which the Claim Administrator has reasonably determined are unavailable from a Participating Provider, benefits for the Covered Services you receive from a Non-Participating Provider will be provided at the payment level described for a Participating Provider.

PHYSICIAN BENEFIT SECTION

This section of your benefit booklet tells you what services are covered and how much will be paid when you receive care from a Physician or other specified Professional Provider.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available under this Benefit Section, services must be Medically Necessary and you must receive such services on or after your Coverage Date.

Remember, whenever the term “you” or “your” is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Surgery

Benefits are available for Surgery performed by a Physician, Dentist or Podiatrist. However, for services performed by a Dentist or Podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under this Health Care Plan had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

1. surgical removal of complete bony impacted teeth;
2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

1. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon’s office or Ambulatory Surgical Facility.

In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

Benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a dental office, oral surgeon's office, Hospital or Ambulatory Surgical Facility if you are under age 19 and have been diagnosed with an autism spectrum disorder or a developmental disability.

For purposes of this provision only, the following definitions shall apply:

Autism spectrum disorder means.....a pervasive developmental disorder described by the American Psychiatric Association or the World Health Organization diagnostic manuals as an autistic disorder, atypical autism, Asperger Syndrome, Rett Syndrome, childhood disintegrative disorder, or pervasive developmental disorder not otherwise specified; or a special education classification for autism or other disabilities related to autism.

Developmental disability means.....a disability that is attributable to an intellectual disability or a related condition, if the related condition meets all of the following conditions:

- It is attributable to cerebral palsy, epilepsy or any other condition, other than a Mental Illness, found to be closely related to an intellectual disability because that condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services similar to those required for those individuals; for purposes of this definition, autism is considered a related condition;
- It manifested before the age of 22;
- It is likely to continue indefinitely; and
- It results in substantial functional limitations in 3 or more of the following areas of major life activity: i) self-care, ii) language, iii) learning, iv) mobility, v) self-direction, and vi) the capacity for independent living.

2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.
3. Sterilization Procedures (even if they are elective).

Medical Care

Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital, a Skilled Nursing Facility, or Substance Use Disorder Treatment Facility or a Residential Treatment Center or
2. you are a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program or
3. you visit your Physician's office or your Physician comes to your home.

Consultations

Your coverage includes benefits for consultations. The consultation must be requested by your Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who also renders Surgery or Maternity Service during the same admission.

Diabetes Self-Management Training and Education

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professionals with expertise in diabetes management. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

Diagnostic Service—Benefits will be provided for those services related to covered Surgery or Medical Care.

Emergency Accident Care

Emergency Medical Care

Electroconvulsive Therapy

Allergy Injections and Allergy Testing

Chemotherapy

Occupational Therapy

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by

a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Occupational Therapy will be limited to a maximum of 60 visits per benefit period.

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Physical Therapy will be limited to a maximum of 60 visits per benefit period.

Chiropractic and Osteopathic Manipulation—Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Your benefits for chiropractic and osteopathic manipulation will be limited to a maximum of 35 visits per benefit period.

Radiation Therapy Treatments

Speech Therapy

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. Outpatient Speech Therapy benefits will be limited to a maximum of 60 visits per benefit period.

Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician.

Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Experimental/Investigational Treatment—Benefits will be provided for routine patient care in conjunction with experimental/investigational treatments when medically appropriate and you have cancer or a terminal condition that according to the diagnosis of your Physician is considered life threatening, if a) you are a qualified individual participating in an Approved Clinical Trial program; and b) if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with an Approved Clinical Trial program. You and/or your Physician are encouraged to call customer service at the toll-free number on your identification card in

advance to obtain information about whether a particular clinical trial is qualified.

Approved Clinical Trials—Benefits for Covered Services for Routine Patient Costs are provided in connection with a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

Acupuncture—Benefits will be provided for acupuncture when rendered by a licensed acupuncturist. Your benefits for acupuncture and chiropractic and osteopathic manipulation will be limited to a combined maximum of 35 visits per benefit period.

Durable Medical Equipment—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates and any other internal and permanent devices. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

Amino Acid-Based Elemental Formulas—Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is medically necessary. If you purchase the formula at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet.

Orthotic Devices

Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary. However, benefits will not be provided for foot orthotics defined as any in-shoe device designed to support the structural components of the foot during weight-bearing activities.

Outpatient Contraceptive Services

Benefits will be provided for prescription contraceptive devices, injections, implants and Outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

Benefits for prescription contraceptive devices and implants will not be subject to a calendar year maximum.

Prosthetic Appliances

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

1. they are required to replace all or part of an organ or tissue of the human body, or
2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required).

Routine Pediatric Hearing Examination—Benefits will be provided for routine pediatric hearing examinations.

Pulmonary Rehabilitation Therapy—Benefits will be provided for outpatient cardiac/pulmonary rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services.

Tobacco Cessation Drugs

Growth Hormone Therapy

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

The benefits provided by the Claim Administrator and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Professional Provider.

Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist, benefits will be provided at 80% of the Maximum Allowance after you have met your program deductible, unless otherwise specified in this benefit booklet. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this benefit booklet and may bill you for the difference between the Claim Administrator's benefit payment and the Provider's charge to you.

When you receive Covered Services (except for those services specified below) in a Participating Provider's office (other than a specialist's office), benefits for Covered Services, including all related Covered Services received on the same day, are subject to a Copayment of \$30 per visit. Benefits will

then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

When you receive Covered Services (except for those services specified below) in a Participating Provider specialist's office, benefits for Covered Services, including all related Covered Services received on the same day, are subject to a Copayment of \$45 per visit. A specialist is a Professional Provider who is **not** a Behavioral Health Practitioner or a Physician in general practice, family practice, internal medicine, psychiatry, obstetrics, gynecology or pediatrics. Benefits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

The following Covered Services are not subject to the office visit Copayment, and benefits will be provided at the general medical/surgical payment level:

- Surgery
- Occupational Therapy
- Physical Therapy
- Speech Therapy

When you receive tobacco cessation drugs from a Participating Provider, benefits will be provided at 100% of the Maximum Allowance and your program deductible will not apply. Benefits will be provided for prescription or over-the-counter tobacco cessation drugs.

Non-Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Non-Participating Provider, benefits will be provided at 70% of the Maximum Allowance after you have met your program deductible.

Emergency Care

Benefits for Emergency Accident Care will be provided at 100% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider. Your program deductible will not apply. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the Emergency Accident Care payment level. Such services will be provided at the benefit payment level for Surgery described in this benefit booklet.

When you receive Covered Services for Emergency Accident Care in a Provider's office, benefits for office visits are subject to a Copayment of \$30 per visit. Benefits for office visits will be provided at 100% of the Maximum Allowance.

Benefits for Emergency Medical Care will be provided at 100% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider. Your program deductible will not apply.

When you receive Covered Services for Emergency Medical Care in a Provider's office, benefits for office visits are subject to a Copayment of \$30 per

visit. Benefits for office visits will be provided at 100% of the Maximum Allowance.

However, Covered Services for Emergency Accident Care and Emergency Medical Care resulting from a criminal sexual assault or abuse will be paid at 100% of the Maximum Allowance whether or not you have met your program deductible. The office visit Copayment will not apply.

Notwithstanding anything in this benefit booklet to the contrary, the method used to determine the Maximum Allowance for Emergency care services will be equal to the greatest of the following three possible amounts:

1. the amount negotiated with Participating Providers for emergency care benefits furnished; or
2. the amount for the emergency care service calculated using the same method the Participating Providers generally uses to determine payments for Non-Participating Provider services but substituting the Participating cost sharing provisions for the Non-Participating Provider cost-sharing provisions; or
3. the amount that would be paid under Medicare for the emergency care service.

Each of these three amounts is calculated excluding any Non-Participating Provider Copayment or Coinsurance imposed with respect to the covered person.

Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists

- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists

who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics

- Speech Therapists
- Other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider or the Claim Administrator.

OTHER COVERED SERVICES

OTHER COVERED SERVICES

This section of your benefit booklet describes “Other Covered Services” and the benefits that will be provided for them.

- The processing, transporting, storing, handling and administration of blood and blood components.
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Your benefits for Private Duty Nursing Service are limited to a maximum of 60 visits per benefit period.
- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- Oxygen and its administration.
- Medical and surgical dressings, supplies, casts and splints.
- Naprapathic Service—Benefits will be provided for Naprapathic Services when rendered by a Naprapath. Benefits for Naprapathic Services will be limited to a maximum of \$1,000 per benefit period.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

After you have met your program deductible, benefits will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance for any of the Covered Services described in this section.

Benefits for ambulance transportation (local ground or air transportation to the nearest appropriately equipped facility) will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance after you have met your program deductible.

Notwithstanding anything else described herein, Providers of ambulance services will be paid based on the amount that represents the billed charges from the majority of the ambulance Providers in the Chicago Metro area as submitted to the Claim Administrator. Benefits for Ambu-

lance Transportation will be paid at the highest level available under this benefit program. However, you will be responsible for any charges in excess of this amount.

When you receive Other Covered Services from a Participating or Non-Participating Provider, benefits for Other Covered Services will be provided at the payment levels previously described in this benefit booklet for Hospital and Physician Covered Services.

Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Physical Therapists
- Retail Health Clinics
- Speech Therapists

who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Physicians
- Podiatrists

- Psychologists
- Dentists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Occupational Therapists
- Optometrists
- Physical Therapists
- Retail Health Clinics
- Speech Therapists
- Other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider or the Claim Administrator.

SPECIAL CONDITIONS AND PAYMENTS

There are some special things that you should know about your benefits should you receive any of the following types of treatments:

HUMAN ORGAN TRANSPLANTS

Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have coverage each will have their benefits paid by their own program.
- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in this benefit booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.
- If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this benefit booklet will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant Surgery.
- the evaluation, preparation and delivery of the donor organ.
- the removal of the organ from the donor.
- the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:

- **Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact the Claim Administrator by telephone before your transplant Surgery has been scheduled. The Claim Administrator will furnish you with the names of Hospitals which have Claim Administrator approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any Hospital that does not have a Claim Administrator approved Human Organ Transplant Program.**

- If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this benefit booklet, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.
- You and your companion are each entitled to benefits for lodging up to a maximum of \$200 per day.
- In addition to the other exclusions of this benefit booklet, benefits will not be provided for the following:
 - Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
 - Travel time and related expenses required by a Provider.
 - Drugs which do not have approval of the Food and Drug Administration.
 - Storage fees.
 - Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.
 - Meals.

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Claim Administrator approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization.

PREVENTIVE CARE SERVICES

In addition to the benefits otherwise provided for in this benefit booklet, (and notwithstanding anything in your benefit booklet to the contrary), the following preventive care services will be considered Covered Services and will not be subject to any deductible, Coinsurance, Copayment or dollar maximum when such services are received from a Participating Provider or Participating Pharmacy that is contracted for such service:

1. evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);
2. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;

3. evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and
4. with respect to women, such additional preventive care and screenings, not described in item 1. above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this preventive care services benefit provision, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November, 2009).

The preventive care services described in items 1. through 4. above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the Claim Administrator's Web site at www.bcbsil.com or contact customer service at the toll-free number on your identification card.

If a recommendation or guideline for a particular preventive health service does not specify the frequency, method, treatment or setting in which it must be provided, the Claim Administrator may use reasonable medical management techniques, including but not limited to, those related to setting and medical appropriateness to determine coverage.

If a covered preventive health service is provided during an office visit and is billed separately from the office visit, you may be responsible for the Copayment or Coinsurance for the office visit only. If an office visit and the preventive health service are billed together and the primary purpose of the visit was not the preventive health service, you may be responsible for the Copayment or Coinsurance for the office visit including the preventive health service.

Preventive Care Services for Adults (or others as specified):

1. Abdominal aortic aneurysm screening for men who have ever smoked
2. Alcohol misuse screening and counseling
3. Aspirin use for men and women of certain ages
4. Blood pressure screening
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal cancer screening for adults over age 50
7. Depression screening
8. Type 2 diabetes screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. HIV screening for all adults at higher risk

11. The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
 - Hepatitis A
 - Hepatitis B
 - Herpes Zoster
 - Human papillomavirus
 - Influenza (Flu shot)
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Tetanus, Diphtheria, Pertussis
 - Varicella
12. Obesity screening and counseling
13. Sexually transmitted infections (STI) prevention
14. Tobacco use screening and cessation interventions for tobacco users
15. Syphilis screening for adults at higher risk
16. Physical Therapy to prevent falls in adults age 65 years and older who are at increased risk for falls
17. Hepatitis C virus (HCV) screening for persons at high risk for infection
18. Hepatitis B virus screening for persons at high risk for infection
19. One-time HCV infection screening of adults born between 1945 and 1965
20. Counseling children, adolescents and young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer
21. Annual screening for lung cancer with low-dose computed tomography in adults ages 55 and older
22. Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls
23. Screening for high blood pressure in adults age 18 years or older
24. Screening for abnormal blood glucose and type II diabetes mellitus as part of cardiovascular risk assessment in adults who are overweight or obese.

Preventive Care Services for Women (including pregnant women or others as specified):

1. Anemia screening on a routine basis for pregnant women

2. Bacteriuria urinary tract screening or other infection screening for pregnant women
3. BRCA counseling about genetic testing for women at higher risk
4. Annual breast cancer mammography screenings, including breast tomosynthesis and, if Medically Necessary, a screening MRI
5. Breast cancer chemoprevention counseling for women at higher risk
6. Breastfeeding comprehensive lactation support and counseling from trained providers, as well as, access to breastfeeding supplies for pregnant and nursing women. Electric breast pumps are limited to two per benefit period
7. Cervical cancer screening for sexually active women
8. Chlamydia infection screening for younger women and women at higher risk
9. Contraception: FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling
10. Domestic and interpersonal violence screening and counseling for all women
11. Folic acid supplements for women who may become pregnant
12. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
13. Gonorrhea screening for all women at higher risk
14. Hepatitis B screening for pregnant women at their first prenatal visit
15. HIV screening and counseling for sexually active women and prenatal HIV testing
16. Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older
17. Osteoporosis screening for women over age 60, depending on risk factors
18. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
19. Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
20. Sexually transmitted infections (STI) counseling for sexually active women
21. Syphilis screening for all pregnant women or other women at increased risk
22. Well-woman visits to obtain recommended preventive services

23. Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence, and device removal
24. Hepatitis C virus (HCV) screening for woman at high risk for infection
25. One-time HCV infection screening of adults born between 1945 and 1965.

Preventive Care Services for Children (or others as specified):

1. Alcohol and drug use assessment for adolescents
2. Behavioral assessments for children of all ages
3. Blood pressure screenings for children of all ages
4. Cervical dysplasia screening for sexually active females
5. Congenital hypothyroidism screening for newborns
6. Major depression disorder("MDD") screening for adolescents
7. Development screening for children under age 3, and surveillance throughout childhood
8. Dyslipidemia screening for children at higher risk of lipid disorder
9. Fluoride chemoprevention supplements for children without fluoride in their water source and topical fluoride applications
10. Gonorrhea preventive medication for the eyes of all newborns
11. Hearing screening for all newborns
12. Height, weight and body mass index measurements
13. Hematocrit or hemoglobin screening
14. Hemoglobinopathies or sickle cell screening for all newborns
15. HIV screening for adolescents at higher risk
16. The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
 - Hepatitis A
 - Hepatitis B
 - Human papillomavirus
 - Influenza (Flu shot)
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Tetanus, Diphtheria, Pertussis
 - Varicella
 - Haemophilus influenzae type b

- Rotavirus
- Inactivated Poliovirus

17. Iron supplements for children ages 6 to 12 months at risk for anemia
18. Lead screening for children at risk for exposure
19. Autism screening for children at 18 and 24 months of age
20. Medical history for all children throughout development
21. Obesity screening and counseling
22. Oral health risk assessment for younger children up to ten years old
23. Phenylketonuria (PKU) screening for newborns
24. Sexually transmitted infections (STI) prevention and counseling for adolescents at higher risk
25. Vision screening for all children
26. Tobacco use interventions, including education or brief counseling, to prevent of tobacco use in school-aged children and adolescents
27. Hepatitis C virus (HCV) screening for persons at high risk for infection
28. Any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

The FDA-approved contraceptive drugs and devices currently covered under this benefit provision are listed on the Contraceptive Drugs & Devices List. This list is available on the Claim Administrator's Web site at www.bcbsil.com and/or by contacting customer service at the toll-free number on your identification card. Benefits are not available under this benefit provision for contraceptive drugs and devices not listed on the Contraceptive Drugs & Devices List. You may, however, have coverage under other sections of this benefit booklet, subject to any applicable deductible, Coinsurance, Copayments and/or benefit maximums. The Contraceptive Drugs & Devices List and the preventive care services covered under this benefit provision are subject to change as FDA guidelines, medical management and medical policies are modified.

Routine pediatric care, women's preventive care (such as contraceptives) and/or Outpatient periodic health examinations Covered Services not included above will be subject to the deductible, Coinsurance, Copayments and/or benefit maximums previously described in your benefit booklet, if applicable.

Preventive care services received from a Non-Participating Provider, or a Non-Administrator Provider facility, or a Non-Participating Pharmacy or other routine Covered Services not provided for under this provision may be subject to the deductible, Coinsurance, Copayments and/or benefit maximums.

Benefits for vaccinations that are considered preventive care services will not be subject to any deductible, Coinsurance, Copayments and/or benefit maximums.

um when such services are received from a Participating Provider or Participating Pharmacy.

Vaccinations that are received from a Non-Participating Provider, or a Non-Administrator Provider facility, or a Non-Participating Pharmacy or other vaccinations that are not provided for under this provision may be subject to the deductible, Coinsurance, Copayments and/or benefit maximum.

WELLNESS CARE

Benefits will be provided for Covered Services rendered to you, even though you are not ill. Benefits will be limited to the following services:

- Routine diagnostic medical procedures;
- Routine EKG;
- Routine x-ray;
- Routine ovarian cancer screening;
- Routine colorectal cancer screening x-ray.

Participating Provider

When you receive Covered Services for wellness care from a Participating Provider, benefits for wellness care will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance and will not be subject to the program deductible.

Non-Participating Provider

When you receive Covered Services for wellness care from a Non-Participating Provider, benefits will be provided at 70% of the Eligible Charge or 70% of the Maximum Allowance after you have met your program deductible.

SKILLED NURSING FACILITY CARE

The following are Covered Services when you receive them in a Skilled Nursing Facility:

1. Bed, board and general nursing care.
2. Ancillary services (such as drugs and surgical dressings or supplies).

No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.

Benefits for Covered Services rendered in an Administrator Skilled Nursing Facility will be provided at 80% of the Eligible Charge after you have met your program deductible.

Benefits for Covered Services rendered in a Non-Administrator Skilled Nursing Facility will be provided at 50% of the Eligible Charge, once you have met your program deductible. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.

AMBULATORY SURGICAL FACILITY

Benefits for all of the Covered Services previously described in this benefit booklet are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

Benefits for services rendered by an Administrator Ambulatory Surgical Facility will be provided at 80% of the Eligible Charge. Benefits for services rendered by a Non-Administrator Ambulatory Surgical Facility will be provided at 50% of the Eligible Charge.

Benefits for Outpatient Surgery will be provided as stated above after you have met your program deductible.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT

Benefits for all of the Covered Services described in this benefit booklet are available for Substance Use Disorder Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Use Disorder Treatment Facility. Inpatient benefits for these Covered Services will also be provided for Substance Use Disorder Rehabilitation Treatment in a Residential Treatment Center. Substance Use Disorder Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with the Claim Administrator or in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.

DETOXIFICATION

Covered Services received for detoxification are not subject to the Substance Use Disorder treatment provisions specified above. Benefits for Covered Services received for detoxification will be provided under the HOSPITAL BENEFITS and PHYSICIAN BENEFITS section of this benefit booklet, the same as for any other condition.

MENTAL ILLNESS AND SUBSTANCE USE DISORDER SERVICES

Benefits for all of the Covered Services described in this benefit booklet are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder. Inpatient benefits for these Covered Services will also be provided for the diagnosis and/or treatment of Inpatient Mental Illness in a Residential Treatment Center. Treatment of a Mental Illness or Substance Use Disorder is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license. Covered Services rendered in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.

MATERNITY SERVICE

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one routine Inpatient examination and c) one Inpatient hearing screening as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth).

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from the Claim Administrator for prescribing a length of stay less than 48 hours (or 96 hours).

Your coverage also includes benefits for elective abortions if legal where performed.

INFERTILITY TREATMENT

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis and/or treatment of infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection.

Infertility means the inability to conceive a child after one year of unprotected sexual intercourse, the inability to conceive after one year of attempts to produce conception, the inability to conceive after and individual is diagnosed with a condition affecting fertility or the inability to attain or maintain a viable pregnancy or sustain a successful pregnancy. The one year requirement will be waived if your Physician determines a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to Chemotherapy or radiation treatments; or, efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

Unprotected sexual intercourse means sexual union between a male and female without the use of any process, device or method that prevents conception including, but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

Benefits for treatments that include oocyte retrievals will be provided only when you have been unable to attain or maintain a variable pregnancy or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that renders such treatment useless. Benefit for treatments that include oocyte retrievals are limited to four completed oocyte retrievals per benefit period.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure to transfer the oocytes or sperm to you. Associated donor medical expenses are also covered, including, but not limited to, physical examinations, laboratory screenings, psychological screenings and prescription drugs.

If an oocyte donor is used, then the completed oocyte retrieval performed on the donor shall count as one completed oocyte retrieval. Following the final completed oocyte retrieval, benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to you.

Special Limitations

Benefits will not be provided for the following:

1. Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from you will be covered if you choose to use a surrogate.
2. Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term.
3. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.
4. Non-medical costs of an egg or sperm donor.
5. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary or required by the Claim Administrator.
6. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.
7. Infertility treatment rendered to your dependents under age 18.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

Benefits for all of the Covered Services previously described in this benefit booklet are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

MASTECTOMY-RELATED SERVICES

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are not limited to:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Inpatient care following a mastectomy for the length of time determined by your attending Physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within 48 hours after discharge;
4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas; and
5. The removal of breast implants when the removal of the implants is a Medically Necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury is not considered cosmetic surgery.

PAYMENT PROVISIONS

Lifetime Maximum

Your benefits are not subject to a lifetime maximum. The total dollar amount that will be available in benefits for you is unlimited.

OUT-OF-POCKET EXPENSE LIMIT

There are separate Out-of-Pocket Expense Limits applicable to Covered Services received from Participating Providers and Non-Participating Providers.

For Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals \$2,500 any additional eligible Claims for Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Participating or Non-Administrator Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Participating Provider or a Non-Administrator Provider
- Copayments resulting from noncompliance with the provisions of the UTILIZATION REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT
- and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed.

If you have Family Coverage and your out-of-pocket expense as described above equals \$7,500 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

For Non-Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals \$7,500, any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the Non-Participating Provider program deductible
- the payments for Covered Services rendered by a Non-Participating Provider for which you are responsible after benefits have been provided

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Administrator Hospital or other Non-Administrator Provider facility
- charges for Outpatient prescription drugs

- the Hospital emergency room Copayment
- Copayments resulting from noncompliance with the provisions of the UTILIZATION REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT
- any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period.

If you have Family Coverage and your expense as described above equals \$22,500 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this plan is terminated, benefits will be provided for, and limited to, the Covered Services of this plan which are rendered by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance use Disorder Treatment Facility, Partial Hospitalization Treatment Program, Residential Treatment Center or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.

HOSPICE CARE PROGRAM

Your Hospital coverage also includes benefits for Hospice Care Program Service.

Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

1. Coordinated Home Care;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services – Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services;
10. Respite Care Service.

The following services are **not** covered under the Hospice Care Program:

1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
5. Transportation, including, but not limited to, Ambulance Transportation.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this benefit booklet.

Benefit Payment for Hospice Care Program Services

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same payment level as described for Inpatient Hospital Covered Services.

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION

When you are being treated for an illness or accident, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage includes benefits for drugs and supplies which are self-administered. This section of your benefit booklet explains which drugs and supplies are covered and the benefits that are available for them. Benefits will be provided only if such drugs and supplies are Medically Necessary.

Although you can go to the Pharmacy of your choice, your benefit for drugs and supplies will be greater when you purchase them from a Participating Pharmacy. You can visit the Claim Administrator's website at www.bcbsil.com for a list of Participating Pharmacies. The Pharmacies that are Participating Prescription Drug Pharmacies may change from time to time. You should check with your Pharmacy before purchasing drugs or supplies to make certain of its participation status.

The benefits of this section are subject to all of the terms and conditions of this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

NOTE: The use of an adjective such as Participating, Preferred or Specialty in modifying a Pharmacy shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Pharmacy. In addition, the omission, non-use or non designation of Participating or any similar modifier or the use of a term such as Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such pharmacy.

For purposes of this Benefit Section only, the following definitions shall apply:

AVERAGE WHOLESALE PRICE.....means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

BRAND NAME DRUG.....means a drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand Name Drug. There may also be situations where a drug's classification changes from Generic to Formulary or Non-Formulary Brand Name due to a change in the market resulting in the Generic Drug being a single source, or the drug product database information changing, which would also result in a corresponding change to your payment obligations from Generic to Formulary or Non-Formulary Brand Name.

COMPOUND DRUGS.....means those drugs or inert ingredients that have been measured and mixed with United States Food and Drug Administration (FDA)-approved pharmaceutical ingredients by a pharmacist to produce a

unique formulation because commercial products either do not exist or do not exist in the correct dosage, size, or form.

COPAYMENT AMOUNT.....means the dollar amount paid by you for each Prescription filled or refilled through a Participating Pharmacy or Non-Participating Pharmacy.

COVERED DRUGS.....means any Legend Drug (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, including disposable syringes and needles needed for self administration):

- (i) Which is Medically Necessary and is ordered by a Health Care Practitioner naming you as the recipient;
- (ii) For which a written or verbal Prescription Order is provided by a Health Care Practitioner;
- (iii) For which a separate charge is customarily made;
- (iv) Which is not consumed or administered at the time and place that the Prescription Order is written;
- (v) For which the FDA has given approval for at least one indication; and
- (vi) Which is dispensed by a Pharmacy and is received by you while covered under this Benefit Section, **except when** received from a Provider's office, or during confinement while a patient in a Hospital or other acute care institution or facility (refer to the EXCLUSIONS provision later in this Benefit Section).

ELIGIBLE CHARGE.....means (a) in the case of a Provider which has a written agreement with a Blue Cross and Blue Shield Plan or the entity chosen by the Claim Administrator to administer its prescription drug program to provide Covered Services to you at the time you receive the Covered Services, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with a Blue Cross and Blue Shield Plan or the entity chosen by the Claim Administrator to provide services to you at the time you receive Covered Services, either of the following charges for Covered Services:

- (i) the charge which the particular Prescription Drug Provider usually charges for Covered Services, or
- (ii) the agreed upon cost between a Participating Pharmacy and a Blue Cross and Blue Shield Plan or the entity chosen by the Claim Administrator to administer its prescription drug program, whichever is lower.

FORMULARY GENERIC OR FORMULARY BRAND NAME DRUG.....means a Generic or Brand Name prescription drug product that is identified on the *Drug List* and is subject to the Formulary Generic or Formulary Brand Name Drug payment level. The *Drug List* is available by accessing the website at www.bcbsil.com.

GENERIC DRUG.....means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Covered Drugs and corresponding payment level, the Claim Administrator utilizes the generic/brand status assigned by a nationally recognized provider of drug product database information. Generic Drugs are available by accessing the website at www.bcbsil.com. You may also contact customer service for more information.

HEALTH CARE PRACTITIONER.....means an Advanced Practice Nurse, doctor of medicine, doctor of dentistry, physician assistant, doctor of osteopathy, doctor of podiatry, or other licensed person with prescription authority.

LEGEND DRUGS.....means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution — Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

MAINTENANCE DRUGS.....means drugs prescribed for chronic conditions and are taken on a regular basis to treat conditions such as high cholesterol, high blood pressure, or asthma.

NATIONAL DRUG CODE (NDC).....means a national classification system for the identification of drugs.

NON-FORMULARY GENERIC OR NON-FORMULARY BRAND NAME DRUG.....means a Generic or Brand Name Drug is subject to the Non-Formulary Generic or Non-Formulary Brand Name Drug payment level. The *Drug List* is available by accessing the website at www.bcbsil.com.

NON-PARTICIPATING PHARMACY OR NON-PARTICIPATING PRESCRIPTION DRUG PROVIDER.....means an independent retail Pharmacy, chain of retail Pharmacies, home delivery Pharmacy or specialty drug Pharmacy which has not entered into a written agreement with the Claim Administrator to provide pharmaceutical services to you or an entity which has not been chosen by the Claim Administrator to administer its prescription drug program services to you at the time you receive the services.

PARTICIPATING PHARMACY OR PARTICIPATING PRESCRIPTION DRUG PROVIDER.....means an independent retail Pharmacy, chain of retail Pharmacies, home delivery Pharmacy or specialty drug Pharmacy which has entered into a written agreement with the Claim Administrator to provide pharmaceutical services to you or an entity chosen by the Claim Administrator to administer its prescription drug program services to you at the time you receive the services.

PHARMACY.....means a state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescriptions to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

PRESCRIPTIONmeans a written or verbal order from a Health Care Practitioner to a pharmacist for a drug to be dispensed. Prescriptions written by a Health Care Practitioner located outside the United States to be dispensed in the United States are not covered under this Benefit Section.

SPECIALTY DRUGS.....means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected, but may also include drugs that are high cost oral medications and/or that have special storage requirements. In addition, patient support and/or education may be required for these drugs. The list of Specialty Drugs is subject to change. To determine which drugs are Specialty Drugs, you should contact your Pharmacy, refer to the *Drug List* by accessing the website at www.bcbsil.com or call the customer service toll-free number on your identification card.

ABOUT YOUR BENEFITS

Drug List

Formulary drugs are selected by the Claim Administrator based upon the recommendations of a committee, which is made up of current and previously practicing physicians and pharmacists from across the country, some of whom are employed by or affiliated with the Claim Administrator. The committee considers drugs regulated by the FDA for inclusion on the *Drug List*. As part of the process, the committee reviews data from clinical studies, published literature and opinions from experts who are not part of the committee. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost and how it compares with drugs currently on the *Drug List*.

The committee considers drugs that are newly approved by the FDA, as well as those that have been on the market for some time. Entire drug classes are also regularly reviewed. Changes to this list can be made from time to time. Positive changes, such as adding drugs to the *Drug List*, occur quarterly after review by our committee. Changes to the *Drug List* that could have an adverse financial impact to you (e.g., drug exclusion, drugs moving to a higher payment tier, or drugs requiring step therapy or prior authorization) occur only annually.

The *Drug List* and any modifications will be made available to you. The Claim Administrator may offer multiple formularies. By accessing the website at www.bcbsil.com or calling the customer service toll-free number on your identification card, you will be able to determine the *Drug List* that applies to you and whether a particular drug is on the *Drug List*.

Prior Authorization Requirement

Prior Authorization (PA): Your benefit plan requires prior authorization for certain drugs. This means that your doctor will need to submit a prior authorization request for coverage of these medications and the request will need to be approved before the medication will be covered under the plan. You and your Physician will be notified of the prescription drug administrator's determination. If Medically Necessary criteria is not met, coverage will be denied and you will be responsible for the full charge incurred. If you do not obtain prior autho-

rization, you will then be responsible for the first \$1,000 or 50% of the Eligible Charge, whichever is less, when you obtain Covered Drugs through a retail Pharmacy or \$1,000 or 50% of the Eligible Charge, whichever is less, when you obtain Covered Drugs through the Home Delivery Prescription Drug Program.

Dispensing Limits

Drug dispensing limits are designed to help encourage medication use as intended by the FDA. Coverage limits are placed on medications in certain drug categories. Limits may include: quantity of covered medication per prescription, quantity of covered medication in a given time period, coverage only for members within a certain age range and coverage only for members of a specific gender. The Claim Administrator evaluates and updates dispensing limits quarterly.

If you require a prescription in excess of the dispensing limit established by the Claim Administrator, ask your Health Care Practitioner to submit a request for clinical review on your behalf. The request will be approved or denied after evaluation of the submitted clinical information. If Medically Necessary criteria is not met, you will be responsible for the full cost of the prescription beyond what your coverage allows.

Payment for benefits covered under this section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum quantity limitation.

To determine if a specific drug is subject to this limitation, you can refer to the Claim Administrator's website at www.bcbsil.com or call the customer service toll-free number on your identification card.

Day Supply

In order to be eligible for coverage under this benefit booklet, the prescribed day supply must be Medically Necessary and must not exceed the maximum day supply limitation prescribed in the benefit booklet. Payment for benefits covered under this Benefit Section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation. Specialty Drugs are limited to a 30 day supply. However, early prescription refills of topical eye medication used to treat a chronic condition of the eye will be eligible for coverage after at least 75% of the predicted days of use and the early refills requested do not exceed the total number of refills prescribed by the prescribing Physician or Optometrist.

Controlled Substances Limitations

If it is determined that you may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized treatment guidelines, any coverage for additional drugs may be subject to a review for Medical Necessity, appropriateness and other coverage restrictions such as limiting coverage to prescription orders written by a certain Provider and/or dispensed by a certain Participating Pharmacy. For purposes of this provision,

controlled substance medications are medications restricted by state or federal laws because of their potential of addiction or misuse.

COVERED SERVICES

Benefits for Medically Necessary Covered Drugs prescribed are available if the drug:

1. Has been approved by the FDA for at least one indication; and
2. Is recognized by substantially accepted peer-reviewed medical literature for treatment of the indication for which the drug is prescribed.

Some drugs are manufactured under multiple brand names and have many therapeutic equivalents. Generic medications may also have several therapeutic equivalents. In such cases, the Claim Administrator may limit benefits to specific therapeutic equivalents. If you do not accept the therapeutic equivalents that are covered under this Benefit Section, the drug purchased will not be covered under any benefit level.

A separate Copayment Amount will apply to each fill of a medication having a unique strength, dosage, or dosage form.

Injectable Drugs

Benefits are available for Medically Necessary injectable drugs which are self-administered that require a written prescription by federal law. Benefits will not be provided for any self-administered drugs dispensed by a Physician.

Immunosuppressant Drugs

Benefits are available for Medically Necessary immunosuppressant drugs with a written prescription after an approved Human Organ Transplant.

Fertility Drugs

Benefits are available for Medically Necessary fertility drugs in connection with the diagnosis and/or treatment of Infertility with a written prescription.

Opioid Antagonists

Benefits will be provided for at least one opioid antagonist drug, including the medication product, administration devices and any Pharmacy administration fees related to the dispensing of the opioid antagonist. This includes refills for expired or utilized opioid antagonists.

Diabetic Supplies for Treatment of Diabetes

Benefits are available for Medically Necessary items of diabetic supplies for which a Health Care Practitioner has written an order. Such diabetes supplies shall include, but are not limited to, the following:

- Test strips specified for use with a corresponding blood glucose monitor
- Lancets and lancet devices

- Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein
- Insulin and insulin analog preparations
- Injection aids, including devices used to assist with insulin injection and needleless systems
- Insulin syringes
- Biohazard disposable containers
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels
- Glucagon emergency kits

A separate Coinsurance Amount will be required for both insulin and insulin syringes regardless if they are obtained on the same day.

Compound Drugs

Benefits are available for Medically Necessary Compound Drugs. The drugs used must meet the following requirements:

- (i) The drugs in the compounded product are FDA approved;
- (ii) The approved product has an assigned National Drug Code (NDC); and
- (iii) The primary active ingredient is a Covered Drug under this Benefit Section.

Compound Drugs will be provided at the Non-Formulary Brand Name Drug payment level.

Cancer Medications

Benefits will be provided for orally administered or self-injected cancer medications that are used to kill or slow the growth of cancerous cells. Your Copayment Amount will not apply to orally administered cancer medications.

Self-Administered Cancer Medications

Benefits will be provided for self-administered cancer medications, including pain medication.

SELECTING A PHARMACY

Participating Pharmacy

When you choose to go to a Participating Pharmacy:

- present your identification card to the pharmacist along with your Prescription Order,
- provide the pharmacist with the birth date and relationship of the patient,
- pay the applicable deductible, if any, and

- pay the appropriate Copayment Amount for each Prescription Order filled or refilled and the pricing difference when it applies to the Covered Drug you receive.

Participating Pharmacies have agreed to accept as payment in full the least of:

- the billed charges, or
- the Eligible Charge, or
- the amount for which you are responsible for as described under the BENEFIT PAYMENT FOR PRESCRIPTION DRUGS provision later in this Benefit Section.

You may be required to pay for limited or non-Covered Services. No Claim forms are required if you follow the above procedures.

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may access the Claim Administrator's website at www.bcbsil.com or call the customer service toll-free number on your identification card.

Non-Participating Pharmacy

If you choose to have a Prescription Order filled at a Non-Participating Pharmacy, you must pay the Pharmacy the full amount of its bill and submit a Claim form to the Claim Administrator or to the prescription drug administrator with itemized receipts verifying that the Prescription Order was filled. The Claim Administrator will reimburse you for Covered Drugs equal to:

- the Copayment Amount indicated,
- less the amount for which you are responsible for as described under the BENEFIT PAYMENT FOR PRESCRIPTION DRUGS provision later in this Benefit Section.

Please refer to the provision entitled "Filing Outpatient Prescription Drug Claims" in the HOW TO FILE A CLAIM AND APPEALS PROCEDURES section of this benefit booklet.

Home Delivery Prescription Drug Program

The Home Delivery Prescription Drug Program provides delivery of Covered Drugs directly to your home address. In addition to the benefits described in this Benefit Section, your coverage includes benefits for Maintenance Drugs and diabetic supplies obtained through the Home Delivery Prescription Drug Program.

Some drugs may not be available through the Home Delivery Prescription Drug Program. For a listing of Maintenance Drugs or if you have any questions about the Home Delivery Prescription Drug Program, need assistance in determining the amount of your payment, or need to obtain the home delivery order form, you may access the Claim Administrator's website at www.bcbsil.com or call the customer service toll-free number on your identification card. Mail the completed form, your prescription and payment to the address indicated on the form.

If you send an incorrect payment amount for the Covered Drug dispensed, you will: (a) receive a credit if the payment is too much; or (b) be billed for the appropriate amount if it is not enough.

When you obtain Maintenance Drugs through the Home Delivery Prescription Drug Program, benefits will be provided according to the **Home Delivery Prescription Drug Program** payment provision described later in this Benefit Section.

For information about the Home Delivery Prescription Drug Program, contact your employer or group administrator.

YOUR COST

Out-of-Pocket Expense Limit

Expenses incurred by you for Covered Services under this Benefit Section will be applied towards the out-of-pocket expense limit for your medical benefits. If, during one benefit period, your out-of-pocket expense limit is reached, benefits will be available for any additional eligible Claims for drugs or diabetic supplies during that benefit period will be paid at 100% of the Eligible Charge.

BENEFIT PAYMENT FOR PRESCRIPTION DRUGS

Retail Pharmacy

The benefits you receive and the Copayment amount you pay will differ depending upon the type of drugs purchased and whether they are obtained from a Participating Prescription Drug Provider.

When you obtain drugs from a Participating Prescription Drug Provider, you must pay a Copayment amount of:

- **\$15 for each prescription** – for generic drugs.
- **\$40 for each prescription** – for Formulary brand name drugs.
- **\$60 for each prescription** – for non-Formulary brand name drugs.
- **\$60 for each prescription** – for self-injectable drugs other than insulin.

When you obtain diabetic supplies from a Participating Prescription Drug Provider, you must pay the Copayment amount described above for each prescription. Benefits will be provided for the remaining Eligible Charge.

When you obtain drugs or diabetic supplies from a non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider), 75% of the Eligible Charge will be paid minus the Copayment amount.

One prescription means up to a 34 consecutive day supply of a drug. Certain drugs may be limited to less than a 34 consecutive day supply. However, for certain Maintenance Drugs, larger quantities may be obtained through the Home Delivery Prescription Drug Program. For information on these drugs, contact your Participating Pharmacy or call the customer service toll-free number on

your identification card. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

Home Delivery Prescription Drug Program

When you obtain drugs and diabetic supplies through the Home Delivery Prescription Drug Program, you must pay a Copayment amount of:

- **\$25 for each prescription** – for generic drugs.
- **\$85 for each prescription** – for Formulary brand name drugs.
- **\$135 for each prescription** – for non-Formulary brand name drugs.
- **\$135 for each prescription** – for self-injectable drugs other than insulin and infertility drugs.

One prescription means up to a 90 consecutive day supply of a drug. Certain drugs may be limited to less than a 90 consecutive day supply. For information on these drugs, contact your Participating Pharmacy or call the customer service toll-free number on your identification card. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

EXCLUSIONS

For purposes of this Benefit Section only, the following exclusions shall apply:

1. Drugs which do not by law require a Prescription Order from a Provider or Health Care Practitioner (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels); and drugs or covered devices for which no valid Prescription Order is obtained.
2. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order) such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as diabetes supplies).
3. Administration or injection of any drugs.
4. Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative).
5. Drugs dispensed in a Physician's or Health Care Practitioner's office or during confinement while as a patient in a Hospital, or other acute care institution or facility, including take-home drugs or samples; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
6. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not

benefits are, or could upon proper claim be, provided under the Workers' Compensation law.

7. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery.
8. Covered Drugs for which the Pharmacy's usual retail price to the general public is less than or equal to your cost determined under this Benefit Section.
9. Drugs which are repackaged by a company other than the original manufacturer.
10. Drugs required by law to be labeled: "Caution — Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs.
11. Drugs dispensed in quantities in excess of the day supply amounts stipulated in this Benefit Section, certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or Health Care Practitioner or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.
12. Legend Drugs which are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.
13. Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically mentioned in this benefit booklet. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
14. Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
15. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card.
16. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your employer's group health care plan, or for which benefits have been exhausted.
17. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.

18. Any Legend Drug which is not listed on the *Drug List* unless specifically covered elsewhere in this benefit booklet and/or is required to be covered by applicable law or regulation.
19. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
20. Retin A or pharmacologically similar topical drugs for persons over the age of 39.
21. Athletic performance enhancement drugs.
22. Allergy serum and allergy testing materials.
23. Some equivalent drugs manufactured under multiple brand names. The Claim Administrator may limit benefits to only one of the brand equivalents available.
24. Certain drug classes where there are over-the-counter alternatives available.
25. All Brand Name Drugs in a drug class where there is an over the counter alternative available.
26. Drugs without superior clinical efficacy which have lower cost therapeutic equivalents or therapeutic alternatives.
27. Medications in depot or long acting formulations that are intended for use longer than the covered days supply amount.
28. Any drug not listed on the formulary is excluded from coverage.
29. Devices and pharmaceutical aids.
30. Repackaged medications and institutional packs.
31. Surgical supplies.
32. Ostomy products.
33. Diagnostic agents, except diabetic test supplies.
34. General anesthetics.
35. Bulk powders.
36. New-to-market FDA-approved drugs which are subject to review by prior to coverage of the drug.

BENEFITS FOR MEDICARE ELIGIBLE COVERED PERSONS

This section describes the benefits which will be provided for Medicare Eligible Covered Persons who are not affected by MSP laws, unless otherwise specified in this benefit booklet (see provisions entitled “Medicare Eligible Covered Persons” in the ELIGIBILITY SECTION of this benefit booklet).

The benefits and provisions described throughout this benefit booklet apply to you, however, in determining the benefits to be paid for your Covered Services, consideration is given to the benefits available under Medicare.

The process used in determining benefits under the Health Care Plan is as follows:

1. determine what the payment for a Covered Service would be following the payment provisions of this coverage.
2. deduct from the charges eligible under Medicare, the amount paid by Medicare. (If you are eligible for Medicare, the amount that is available from Medicare will be deducted whether or not you have enrolled and/or received payment from Medicare.)
3. the lesser of the two amounts determined in accordance with step 1 and step 2 above is the amount that will be paid under the Health Care Plan.

When you have a Claim, you must send the Claim Administrator a copy of your Explanation of Medicare Benefits (“EOMB”) in order for your Claim to be processed. In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used.

EXCLUSIONS - WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

— **Hospitalization, services and supplies which are not Medically Necessary.**

No benefits will be provided for services which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of the Claim Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
- Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.

The Claim Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your health care plan. In most instances this decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's decision, your plan provides for an appeal of that decision.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, THE CLAIM ADMINISTRATOR WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY.

- Services or supplies that are not specifically mentioned in this benefit booklet.
- Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.
- Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

- Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.
- Services or supplies that do not meet accepted standards of medical and/or dental practice.
- Investigational Services and Supplies and all related services and supplies, except as may be provided under this benefit booklet for a) the cost of routine patient care associated with Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with a qualified cancer trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).
- Custodial Care Service.
- Long Term Care Service.
- Respite Care Service, except as specifically mentioned under the Hospice Care Program.
- Inpatient Private Duty Nursing Service.
- Routine physical examinations, unless otherwise specified in this benefit booklet.
- Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Charges for failure to keep a scheduled visit or charges for completion of a Claim form.
- Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this benefit booklet.
- Blood derivatives which are not classified as drugs in the official formularies.

- Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, which are not Medically Necessary, except as specifically mentioned in this benefit booklet.
- Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.
- Routine foot care, except for persons diagnosed with diabetes.
- Immunizations, unless otherwise specified in this benefit booklet.
- Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this benefit booklet.
- Maintenance Care.
- Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation, except as may be provided under this benefit booklet for Autism Spectrum Disorder(s).
- Hearing aids or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this benefit booklet.
- Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this benefit booklet.
- Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
- Wigs (also referred to as cranial prostheses), unless otherwise specified in this benefit booklet.
- Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this benefit booklet.
- Nutritional items such as infant formulas, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins and herbal supplements, other than those specifically named in this benefit booklet.
- Reversals of sterilization.
- Surgery for morbid obesity (including, but not limited to, bariatric Surgery).
- Gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery), including related services and supplies.
- Appliances for Temporomandibular Joint Dysfunction.

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies when you have health care coverage through more than one group program. The purpose of COB is to insure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claim Administrator of the existence of such other group coverages. COB does not apply to the Out-patient Prescription Drug Program Benefit Section.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

1. The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.
2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this "birthday" type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.
 - However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;
 - when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to

notify the Claim Administrator, and upon its request to provide a copy, of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

The Claim Administrator has the right in administering these COB provisions to:

- pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.
- recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person or other organization.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This CONTINUATION COVERAGE RIGHTS UNDER COBRA section does not apply to Domestic Partners and their children. This CONTINUATION COVERAGE RIGHTS UNDER COBRA section does not apply to your dependent who is a party to a Civil Union and their children.

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE RIGHTS UNDER COBRA. See your employer or Group Administrator should you have any questions about COBRA.

Introduction

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period Of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension Of 18-Month Period Of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed Of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

CONTINUATION OF COVERAGE FOR DOMESTIC PARTNERS

The purpose of this section of your benefit booklet is to explain the options available for temporarily continuing your coverage after termination, if you are covered under this benefit booklet as the Domestic Partner of an Eligible Person or as the dependent child of a Domestic Partner. Your continued coverage under this benefit booklet will be provided only as specified below. Please read the provisions very carefully.

Continuation of Coverage

If you are the Domestic Partner or the dependent child of a Domestic Partner and you lose coverage under this benefit booklet, you have the same options as the spouse or dependent child of an Eligible Person to continue your coverage. The options available to a spouse or a dependent child are described in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable to your Group.

NOTE: Certain employers may not be required to offer COBRA continuation coverage. See your Group Administrator if you have any questions about COBRA.

In addition to the events listed in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Domestic Partnership with the Eligible Person terminates. Your Domestic Partnership will terminate if your partnership no longer meets the criteria described in the definition of “Domestic Partnership” in the DEFINITIONS SECTION of this benefit booklet. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

CONTINUATION OF COVERAGE FOR PARTIES TO A CIVIL UNION

The purpose of this section of your benefit booklet is to explain the options available for temporarily continuing your coverage after termination, if you are covered under this benefit booklet as the party to a Civil Union of an Eligible Person or as the dependent child of a party to a Civil Union. Your continued coverage under this benefit booklet will be provided only as specified below. Please read the provisions very carefully.

Continuation of Coverage

If you are a dependent who is party to a Civil Union or their child and you lose coverage under this benefit booklet, you have the same options as the spouse or dependent child of an Eligible Person to continue your coverage. The options available to a spouse or a dependent child are described in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable to your Group.

NOTE: Certain employers may not be required to offer COBRA continuation coverage. See your Group Administrator if you have any questions about COBRA.

In addition to the events listed in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Civil Union Partnership with the Eligible Person terminates. Your Civil Union Partnership will terminate if your partnership no longer meets the criteria described in the definition of "Civil Union" in the DEFINITIONS SECTION of this benefit booklet. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

HOW TO FILE A CLAIM AND APPEALS PROCEDURES

In order to obtain your benefits under this benefit program, it is necessary for a Claim to be filed with the Claim Administrator. To file a Claim, usually all you will have to do is show your ID card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember however, it is your responsibility to ensure that the necessary Claim information has been provided to the Claim Administrator.

Once the Claim Administrator receives your Claim, it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how your benefits were calculated. In some cases the Claim Administrator will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from your Employee Benefits Department or from the Claim Administrator's office.
2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge.
3. Mail the completed Claim Form with attachments to:

Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, Illinois 60680-4112

In any case, Claims should be filed with the Claim Administrator on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished the succeeding calendar year.) **Claims not filed within the required time period will not be eligible for payment.**

Should you have any questions about filing Claims, ask your Employee Benefits Department or call the Claim Administrator's office.

FILING OUTPATIENT PRESCRIPTION DRUG CLAIMS

In certain situations, you will have to file your own Claims in order to obtain benefits for Outpatient prescription drugs. This is primarily true when you did not receive an identification card, the Pharmacy was unable to transmit a

Claim or you received benefits from a non-Participating Prescription Drug Provider. To do so, follow these instructions:

1. Complete a prescription drug Claim Form. These forms are available from your Employee Benefits Department or from the Claim Administrator's office.
2. Attach copies of all Pharmacy receipts to be considered for benefits. These receipts must be itemized.
3. Mail the completed Claim Form with attachments to:

Blue Cross and Blue Shield of Illinois
P.O. Box 14624
Lexington, KY 40512-4624

In any case, Claims must be filed no later than one year after the date a service is received. Claims not filed within one year from the date a service is received will not be eligible for payment.

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIMS DETERMINATIONS

The Claim Administrator will usually pay all Claims within 30 days of receipt of all information required to process a Claim. The Claim Administrator will usually notify you, your valid assignee or your authorized representative, when all information required to pay a Claim within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provisions in the GENERAL PROVISIONS section of this benefit booklet.) If you fail to follow the procedures for filing a pre-service claim (as defined below), you will be notified within 5 days (or within 24 hours in the case of a failure regarding an urgent care/expedited clinical claim [as defined below]). Notification may be oral unless the claimant requests written notification.

If a Claim Is Denied or Not Paid in Full

If a claim for benefits is denied in whole or in part, you will receive a notice from the Claim Administrator within the following time limits:

1. For non-urgent pre-service claims, within 15 days after receipt of the claim by the Claim Administrator. A "pre-service claim" is any non-urgent request for benefits or for a determination, with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
2. For post-service Claims, within 30 days after receipt of the Claim by the Claim Administrator. A "post-service claim" is a Claim as defined above.

If the Claim Administrator determines that special circumstances require an extension of time for processing the claim, for non-urgent pre-service and post-service claims, the Claim Administrator shall notify you or your authorized representative in writing of the need for extension, the reason for the

extension, and the expected date of decision within the initial period. In no event shall such extension exceed 15 days from the end of such initial period. If an extension is necessary because additional information is needed from you, the notice of extension shall also specifically describe the missing information, and you shall have at least 45 days from receipt of the notice within which to provide the requested information.

If the claim for benefits is denied in whole or in part, you or your authorized representative shall be notified in writing of the following:

- a. The reasons for denial;
- b. A reference to the benefit plan provisions on which the denial is based;
- c. A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
- d. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), diagnosis, treatment and denial codes with their meanings and the standards used;
- e. An explanation of the Claim Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;
- f. In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other benefit information may be available in such non-English language(s);
- g. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- h. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- i. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- j. In the case of a denial of an urgent care/expedited clinical claim, a description of the expedited review procedure applicable to such claims. An urgent care/expedited claim decision may be provided orally, so long as written notice is furnished to the claimant within 3 days of oral notification;

- k. Contact information for applicable office of health insurance consumer assistance or ombudsman.
3. For benefit determinations relating to urgent care/expedited clinical claim (as defined below), such notice will be provided no later than 24 hours after the receipt of your claim for benefits, unless you fail to provide sufficient information. You will be notified of the missing information and will have no less than 48 hours to provide the information. A benefit determination will be made within 48 hours after the missing information is received.
4. For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your claim for benefits.

An “urgent care/expedited clinical claim” is any pre-service claim for benefits for medical care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

INQUIRIES AND COMPLAINTS

An “**Inquiry**” is a general request for information regarding claims, benefits, or membership.

A “**Complaint**” is an expression of dissatisfaction by you either orally or in writing.

The Claim Administrator has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to, the following:

- Claims
- Quality of care

When your Complaint relates to dissatisfaction with a claim denial (or partial denial), then you have the right to a claim review/appeal as described in the CLAIM APPEAL PROCEDURES.

To pursue an Inquiry or a Complaint, you may contact **Customer Service** at the number on the back of your ID card, or you may write to:

**Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, Illinois 60601**

When you contact Customer Service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of receipt by Customer Service. Sometimes the acknowledgement and the response will be combined. If the Claim Administrator needs more information,

you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information, you will be contacted.

An appeal is an oral or written request for review of an Adverse Benefit Determination (as defined below) or an adverse action by the Claim Administrator, its employees or a participating provider.

CLAIM APPEAL PROCEDURES - DEFINITIONS

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your ID card.

An **“Adverse Benefit Determination”** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator or your Employer and the Claim Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination of the Employer’s benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

In addition, an Adverse Benefit Determination, also includes an “Adverse Determination.” An **“Adverse Determination”** means a determination by the Claim Administrator or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a Covered Service has been reviewed and, based upon the information provided, does not meet the Claim Administrator’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. For purposes of this benefit program, we will refer to both an Adverse Determination and an Adverse Benefit Determination as an Adverse Benefit Determination, unless indicated otherwise.

A **“Final Internal Adverse Benefit Determination”** means an Adverse Benefit Determination that has been upheld by the Claim Administrator or your Employer at the completion of the Claim Administrator’s or Employer’s internal review/appeal process.

CLAIM APPEAL PROCEDURES

If you have received an Adverse Benefit Determination, you may have your Claim reviewed on appeal. The Claim Administrator will review its decision in accordance with the following procedures. The following review procedures will also be used for Claim Administrator's (i) coverage determinations that are related to non-urgent care that you have not yet received if approval by your plan is a condition of your opportunity to maximize your benefits and (ii) coverage determinations that are related to care that you are receiving at the same time as the determination. Claim reviews are commonly referred to as "appeals."

Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the Claim Administrator to request a claim review. The Claim Administrator will need to know the reasons why you do not agree with the Adverse Benefit Determination. You may call 1-877-284-9302 or send your request to:

Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690

In support of your Claim review, you have the option of presenting evidence and testimony to the Claim Administrator, by phone or in person at a location of the Claim Administrator's choice. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the Claim review process.

The Claim Administrator will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of your Claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale and information will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. The appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors, but who were not involved in making the initial denial of your Claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator or your Employer.

Urgent Care/Expedited Clinical Appeals

If your appeal relates to an urgent care/expedited clinical claim, or health care services, including but not limited to, procedures or treatments ordered by a health care provider, the denial of which could significantly increase the risk to the claimant's health, then you may be entitled to an appeal on an expedited ba-

sis. Before authorization of benefits for an ongoing course of treatment is terminated or reduced, the Claim Administrator will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an urgent care/expedited pre-service or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Claim Administrator shall render a determination on the appeal within 24 hours after it receives the requested information.

Other Appeals

Upon receipt of a non-urgent pre-service or post-service appeal the Claim Administrator shall render a determination of the appeal within 30 days after the appeal has been received by the Claim Administrator or such other time as required or permitted by law.

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters at 1-800-538-8833. The Claim Administrator offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9431, or call the number on the back of your ID card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Notice of Appeal Determination

The Claim Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, orally of its determination followed-up by a written notice of the determination.

The written notice will include:

1. The reasons for the determination;
2. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;

3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), and information about how to obtain diagnosis, treatment and denial codes with their meanings;
4. An explanation of the Claim Administrator's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal;
5. In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other benefit information may be available in such non-English language(s);
6. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
7. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
8. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
9. A description of the standard that was used in denying the claim and a discussion of the decision.

If the Claim Administrator's or your Employer's decision is to continue to deny or partially deny your Claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the INDEPENDENT EXTERNAL REVIEW section below.

If an appeal is not resolved to your satisfaction, you may appeal the Claim Administrator's decision to the Illinois Department of Insurance. The Illinois Department of Insurance will notify the Claim Administrator of the appeal. The Claim Administrator will have 21 days to respond to the Illinois Department of Insurance.

Some of the operations of the Claim Administrator are regulated by the Illinois Department of Insurance. Filing an appeal does not prevent you from filing a Complaint with the Illinois Department of Insurance or keep the Illinois Department of Insurance from investigating a Complaint.

You must exercise the right to internal appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity. If you have an adverse appeal determination, you may file civil action in a state or federal court.

STANDARD EXTERNAL REVIEW

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO).

An “**Adverse Benefit Determination**” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator or your Employer and the Claim Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination of the Employer’s benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

A “**Final Internal Adverse Benefit Determination**” means an Adverse Benefit Determination that has been upheld by the Claim Administrator at the completion of the Claim Administrator’s internal review/appeal process.

1. **Request for external review.** Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review. If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
2. **Preliminary review.** Within 5 business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:
 - a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
 - b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);

- c. You have exhausted the Claim Administrator's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the **EXHAUSTION** section below for additional information and exhaustion of the internal appeal process; and
- d. You or your authorized representative have provided all the information and forms required to process an external review.

You will be notified within 1 business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).

- 3. Referral to Independent Review Organization.** When an eligible request for external review is completed within the time period allowed, Claim Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the Claim Administrator will take action against bias and to ensure independence. Accordingly, the Claim Administrator must contract within at least (3) IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

- a. Utilization of legal experts where appropriate to make coverage determinations under the plan.
- b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
- c. Within 5 business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the

documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within 1 business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.

- d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within 1 business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claim Administrator.
- e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
 - (1) Your medical records;
 - (2) The attending health care professional's recommendation;
 - (3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;
 - (4) The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
 - (5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

- (6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
 - (7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
 - f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claim Administrator and you or your authorized representative.
 - g. The notice of final external review decision will contain:
 - (1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - (2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - (3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 - (4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - (5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator and you or your authorized representative;
 - (6) A statement that judicial review may be available to you or your authorized representative; and
 - (7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
 - h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. **Reversal of plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claim Administrator immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

EXPEDITED EXTERNAL REVIEW

1. **Request for expedited external review.** Claim Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claim Administrator at the time you receive:
 - a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
 - b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.
2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in STANDARD EXTERNAL REVIEW section above.
3. **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review

the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process.

4. **Notice of final external review decision.** The Claim Administrator's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the STANDARD EXTERNAL REVIEW section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

EXHAUSTION

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the Claim Administrator to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

GENERAL PROVISIONS

1. CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Claim Administrator hereby informs you that it has contracts with certain Providers ("Administrator Providers") in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under the Health Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

- receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claim Administrator was obligated to pay the Administrator Provider, or
- pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Administrator Providers other substantial allowances under the Claim Administrator's contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by the Claim Administrator as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet shall be based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Your Employer has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how the Claim Administrator's separate financial arrangements with Providers work, please consider the following example:

- a. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is \$1,000. How is the \$1,000 bill paid?
- b. You personally will have to pay the deductible and Coinsurance amounts set out in your benefit booklet.
- c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital's Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the \$1,000 Hospital bill would be reduced by 30% to \$700 for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

- d. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the \$1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of \$700, or \$140. You should note that your 20% Coinsurance is based on the full \$1,000 Hospital bill, after it is reduced by the applicable ADP.
- e. After taking into account the deductible and Coinsurance amounts, the Claim Administrator will satisfy its portion of the Hospital bill. In most cases, the Claim Administrator has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money the Claim Administrator would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is \$1,000, your deductible has already been satisfied, and your Coinsurance is \$140, then the Claim Administrator has to satisfy the rest of the Hospital bill, or \$860. Assuming the Claim Administrator has a contract with the Hospital, the Claim Administrator will usually be able to satisfy the \$860 bill that remains after your Coinsurance and deductible, by paying less than \$860 to the Hospital, often substantially less than \$860. The Claim Administrator receives, and keeps for its own account, the difference between the \$860 bill and whatever the Claim Administrator ultimately pays under its contracts with Administrator Providers, and neither you nor your Employer are entitled to any part of these savings.

BlueCard® Program

Under the BlueCard® Program, when you access Covered Services within the geographic area served by a Host Blue, Claim Administrator will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

Whenever you access Covered Services outside the Claim Administrator's service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue passes on to the Claim Administrator.

To help you understand how this calculation would work, please consider the following example:

- a. Suppose you receive Covered Services for an illness while you are on vacation outside of Illinois. You show your identification card to the provider to let him or her know that you are covered by the Claim Administrator.
- b. The provider has negotiated with the Host Blue a price of \$80, even though the provider's standard charge for this service is \$100. In this example, the provider bills the Host Blue \$100.

- c. The Host Blue, in turn, forwards the claim to the Claim Administrator and indicates that the negotiated price for the covered service is \$80. The Claim Administrator would then base the amount you must pay for the service – the amount applied to your deductible, if any, and your coinsurance percentage – on the \$80 negotiated price, not the \$100 billed charge.
- d. So, for example, if your coinsurance is 20%, you would pay \$16 (20% of \$80), not \$20 (20% of \$100). You are not responsible for amounts over the negotiated price for a covered service.

PLEASE NOTE: The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this benefit booklet.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over – or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, your claims for Covered Services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (Refer to the description of negotiated price under Section A, BlueCard Program) made available to the Claim Administrator by the Host Blue.

Non-Participating Healthcare Providers Outside The Claim Administrator's Service Area

a. Liability Calculation

(1) In General

When Covered Services are provided outside of Claim Administrator's service area by non-participating Providers, the amount(s) you pay for such services will be calculated using the methodology described in the Booklet for non-participating Providers located inside our service area. You may be responsible for the difference between the amount that the non-participating Provider bills and the payment Claim Administrator will make for the Covered Services as set forth in this paragraph.

(2) Exceptions

In some exception cases, Claim Administrator may, but is not required to, in its sole and absolute discretion, negotiate a payment with such non-participating Provider on an exception basis.

Value-Based Programs BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not bear any portion of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees of such arrangement, except when a Host Blue passes these fees to the Claim Administrator through average pricing or fee schedule incentive adjustments.

Under the Agreement Employer has with Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of Illinois and Employer will not impose cost sharing for Care Coordinator Fees.

Value-Based Programs Negotiated Arrangements

If the Claim Administrator enters into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Employer on your behalf, Blue Cross and Blue Shield of Illinois will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted in the BlueCard Program section.

BlueCard Worldwide® Program

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the BlueCard Worldwide® Program when accessing Covered Services. The BlueCard Worldwide® Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the BlueCard Worldwide Program assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the BlueCard Worldwide Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts/deductibles, coinsurances, etc. In such cases, the hospital will submit your claims to the BlueCard Worldwide Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact the Claim Administrator to obtain recertification for non-emergency inpatient services.**

Outpatient Services

Outpatient Services are available for Emergency Care. Physicians, urgent care centers and other Outpatient Providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

Submitting a BlueCard Worldwide Claim

When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide International claim form and send the claim form with the provider's itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Plan the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submission, you should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

Under BlueCard, when you receive health care services outside of Illinois and from a Provider which does not have a contract with the Claim Administrator, the amount you pay, if not covered by a flat dollar Copayment, for Covered Services is calculated on the lower of:

You will be entitled to benefits for health care services received by you either inside or outside the geographic area the Claim Administrator serves, if those health care services are covered under this Health Care Plan. Due to variations in Host Blue utilization management programs, you may receive benefits for some health care services obtained outside the geographic area the Claim Administrator serves, even though you might not otherwise have received benefits if those health care services were rendered inside the geographic area the Claim Administrator serves.

But in no event will you be entitled to benefits for health care services, wherever you received them, that are specifically excluded or limited from coverage under this Health Care Plan.

Servicing Plans

In some instances, the Claim Administrator has entered into agreements with other Blue Cross and Blue Shield Plans (“Servicing Plans”) to provide, on the Claim Administrator’s behalf, Claim Payments and certain administrative services for you. Under these agreements, the Claim Administrator will reimburse each Servicing Plan for all Claim Payments made on the Claim Administrator’s behalf for you.

Certain Servicing Plans may have contracts similar to the contracts described above with certain Providers (“Servicing Plan Providers”) in their service area. The Servicing Plan will process your claim in accordance with the Servicing Plan’s applicable contract with the Servicing Plan Provider. Further, all amounts payable to the Servicing Plan by the Claim Administrator for Claim Payments made by the Servicing Plan and applicable service charges, and all benefit maximum amounts and any required deductible and Coinsurance amounts under this Health Care Plan will be calculated on the basis of the Servicing Plan Provider’s Eligible Charge for Covered Services rendered to you or the cost agreed upon between the Servicing Plan and the Claim Administrator for Covered Services that the Servicing Plan passes to the Claim Administrator, whichever is lower.

Often, the agreed upon cost is a simple discount. Sometimes, however, the agreed upon cost may represent either an estimated discount or an average discount received or expected by the Servicing Plan based on separate financial arrangements with Servicing Plan Providers.

In other instances, laws in a small number of states dictate the basis upon which the Coinsurance is calculated. When Covered Services are rendered in those states, the Coinsurance amount will be calculated using the state’s statutory method.

2. THE CLAIM ADMINISTRATOR’S SEPARATE FINANCIAL ARRANGEMENTS REGARDING PRESCRIPTION DRUGS

Claim Administrator’s Separate Financial Arrangements with Prescription Drug Providers

The Claim Administrator hereby informs you that it has contracts, either directly or indirectly, with Prescription Drug Providers (“Participating Prescription Drug Providers”) to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under this Health Care Plan. Under its contracts with Participating Prescription Drug Providers, the Claim Administrator may receive from these Providers discounts for prescription drugs dispensed to you. Actual discounts used to calculate your share of the cost of prescription drugs will vary. Some discounts are currently based on Average

Wholesale Price (“AWP”) which is determined by a third party and is subject to change. You understand that the Claim Administrator may receive such discounts. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances.

For the home delivery pharmacy and specialty pharmacy program owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the home delivery pharmacy and/or specialty pharmacy program. The Claim Administrator pays a fee to Prime for pharmacy benefit services. A portion of Prime’s PBM fees are tied to certain performance standards, including, but not limited to, Claims processing, customer service response, and home delivery processing.

“Weighted Paid Claim” refers to the methodology of counting Claims for purposes of determining the Claim Administrator’s fee payment to Prime. Each retail (including Claims dispensed through PBM’s Specialty Pharmacy program) paid Claim will be weighted according to the days’ supply dispensed. A paid Claim is weighted in 34 day supply increments, so a 1-34 days’ supply is considered 1 weighted Claim, a 35-68 days’ supply is considered 2 weighted Claims, and the pattern continues up to 6 weighted Claims for 171 or more days’ supply. The Claim Administrator pays Prime a Program Management Fee (“PMF”) on a per weighted Claim basis.

The amounts received by Prime from the Claim Administrator, Pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a Claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to the Claim Administrator (as described above), administrative fees charge by Prime to Pharmacies and administrative fees charged by prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to you as expenses, or accrue to the benefit of you, unless otherwise specifically set forth in this benefit booklet. Additional information about these types of fees or the amount of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 3% of the total sales for all rebatable products of such manufacturer dispensed during any given calendar year to members of the Claim Administrator and other Blue Plan operating divisions.

Claim Administrator’s Separate Financial Arrangements with Pharmacy Benefit Managers

The Claim Administrator owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the Claim Administrator has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as “Pharmacy Benefit Managers”) to provide, on the Claim Administrator’s behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to

receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of such rebates as they are figured into the pricing of the product.

Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of the Claim Administrator, but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufactures to cover the administrative costs of processing late payments). The Claim Administrator may receive such rebates from Prime. You are not entitled to receive any portion of any such rebates as they are calculated into the pricing of the product.

3. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

- a. Under this Health Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. The Claim Administrator is specifically authorized by you to determine to whom any benefit payment should be made.
- b. Once Covered Services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.
- c. A Covered Person's claim for benefits under this Health Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person. Coverage under this Health Care Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

4. YOUR PROVIDER RELATIONSHIPS

- a. The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.
- b. The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.

- c. The use of an adjective such as Participating, Administrator or approved in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Participating, Administrator, approved or any similar modifier or the use of a term such as Non-Administrator or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.
- d. Each Provider provides Covered Services only to you and does not deal with or provide any services to your Employer (other than as an individual Covered Person) or your Employer's ERISA Health Benefit Program.

5. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Health Care Plan as described in this benefit booklet must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this benefit booklet for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator's records or in care of your Employer and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records. The Claim Administrator may also provide such notices electronically to the extent permitted by applicable law.

6. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Health Care Plan as described in this benefit booklet, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet.

7. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under the Health Care Plan, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Claim Administrator or its agent, and agree that any such Provider, person or other entity may furnish to the Claim Administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to

such illness, injury, Claim or Claims. In addition, the Claim Administrator may furnish similar information and records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish the Claim Administrator and/or your Employer or group administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the Claim Administrator be able to make Claim Payments in accordance with MSP laws.

8. VALUE BASED DESIGN PROGRAMS

The Claim Administrator and your Employer has the right to offer medical management programs, a quality improvement programs and health behavior wellness, maintenance, or improvement program that allows for a reward, a contribution, a penalty, a differential in premiums or medical, prescription drug or equipment Copayments, Coinsurance or deductibles, or costs or a combination of these incentives or disincentives for participation in any such program offered or administered by the Claim Administrator or an entity chosen by the Claim Administrator to administer such program. In addition, discount programs for various health and wellness-related or insurance-related or other items and services may be available from time-to-time. Such programs may be discontinued with or without notice.

Contact your Employer for additional information regarding any value based programs offered by your Employer.

9. IDENTITY THEFT PROTECTION SERVICES

The Claim Administrator makes available at no additional cost to you identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by the Claim Administrator's designated outside vendor and acceptance or declination of these services is optional to you. If you wish to accept such identity theft protection services you will need to individually enroll in the program online at www.bcbsil.com or telephonically by calling the toll-free telephone number on your identification card. Services may automatically end if you are no longer meet the definition of an Eligible Person. Services may change or be discontinued at any time with or without notice and the Claim Administrator does not guarantee that a particular vendor or service will be available at any given time. The services are provided as a convenience and are not considered covered benefits under this benefit booklet.

REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to negligence of a third party and benefits are provided for Covered Services described in this benefit booklet, you agree:

- a. the Claim Administrator has the rights to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which the Claim Administrator has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.
- b. the Claim Administrator is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Claim Administrator provided for that sickness or injury.

The Claim Administrator shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses for which the Claim Administrator has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability. (See provisions of this benefit booklet regarding "Claim Administrator's Separate Financial Arrangements with Providers.")

END OF BENEFIT BOOKLET

The information which follows is provided to you by BRG Sports, Inc.. The Claim Administrator is not responsible for its contents.

**EMPLOYEE RETIREMENT INCOME
SECURITY ACT OF 1974
PLAN ADMINISTRATION INFORMATION**

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet. Your Plan Administrator has determined that this information together with the information contained in your booklet is the Summary Plan Description required by ERISA.

In furnishing this information, the Claim Administrator is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

NAME OF PLAN:

BRG Sports Welfare Benefit Plan

PLAN SPONSOR:

Name: BRG Sports, Inc.

Address: 6225 North State Highway 161
Irving, TX 75038

PLAN NUMBER:

501

PLAN ADMINISTRATOR:

Name: BRG Sports, Inc.

Address: 6225 North State Highway 161
Irving, TX 75038

Telephone Number: (469) 417-6605

TYPE OF PLAN:

Welfare Benefit Plan

TYPE OF PLAN ADMINISTRATION:

The benefits are self-funded by BRG Sports, Inc. Claims are processed by Blue Cross and Blue Shield of Illinois.

CLAIM ADMINISTRATION:

Claims for benefits should be directed to:

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

AGENT FOR SERVICE OF LEGAL PROCESS:

BRG Sports

COLLECTIVE BARGAINING AGREEMENTS:

A copy of the collective bargaining agreement can be obtained upon written request to the Plan Administrator and is available for examination.

ELIGIBILITY:

The provisions regarding participation in the Plan are explained in this booklet.

BENEFITS AND ADMINISTRATION:

Benefits are described in this booklet. However, these benefits may change from time to time.

Minimum Maternity Benefits

Group health plans and health insurance issuers offering group insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay in excess of the above periods.

LOSS OF BENEFITS, INELIGIBILITY, DISQUALIFICATION AND SUSPENSION:

The provisions regarding ineligibility, descriptions of circumstances which may result in disqualification, suspension, denial of benefits, reduction or termination of coverage are explained in this booklet.

CONTRIBUTIONS:

Both the employer and employee contribute to the Plan. Amounts are paid on a pre-tax basis in accordance with the BRG Sports Flexible Benefit Plan.

FUNDING ARRANGEMENTS:

All benefits paid under this Plan shall be paid in case from the general assets of the employer.

TERMINATION OF PLAN OR BANKRUPTCY:

Although the Plan Sponsor anticipates offering benefits under the Plan indefinitely, the Plan Sponsor reserves the right to terminate the Plan or amend or eliminate benefits under the Plan at any time.

PLAN YEAR:

01/01 – 12-31

QUALIFIED CHILD SUPPORT ORDERS:

Participants and beneficiaries can obtain, without charge, a copy of the Plan's procedures governing qualified medical support order ("QMCSO") determinations from the Plan Administrator.

NO CONTRACT OF EMPLOYMENT:

The Plan does not create a contract of employment or create any obligation of continued service of any employee.

HOW TO GET YOUR BENEFITS:

This information is explained in the section of this booklet entitled "HOW TO FILE A CLAIM."

CLAIMS PROCEDURE:

This information is explained in the section of this booklet entitled "HOW TO FILE A CLAIM".

CLAIM APPEAL PROCEDURES

This information is explained in the section of this booklet entitled "HOW TO FILE A CLAIM."

CLAIM REVIEW PROCEDURE:

This information is explained in the section of this booklet entitled "HOW TO FILE A CLAIM."

STATEMENT OF ERISA RIGHTS:

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

- a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department

of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- c. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage:

- a. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this booklet and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- b. Reduction or elimination of exclusionary periods of coverage for Preexisting Conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a certificate of Creditable Coverage, free of charge from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a preexisting exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries:

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit under the plan or exercising your rights under ERISA.

Enforce Your Rights:

If your Claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen the plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees.

If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your Claim is frivolous.

Assistance with Your Questions:

If you have any questions about the plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue, N. W., Washington, D. C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA):

Group health plans and health insurance issuers, under USERRA, must protect all persons who perform duty, voluntarily or involuntarily, in the "uniformed services", which include the Army, Navy, Marine Corps, Air Force, Coast Guard and Public Health Service commissioned corps, as well as the reserve components of each of these services. If you are a pre-service member returning from a period of service in the uniformed services, you are entitled to reemployment from your Employer if you meet the following criteria:

- you held the job prior to service;
- you gave notice to your Employer that you were leaving your employment for service in the uniformed services, unless giving notice was precluded by military necessity or otherwise impossible or unreasonable;

- your cumulative period of service did not exceed five years;
- you were not released from service under dishonorable or other punitive conditions; and
- you reported back to the job in a timely manner or submitted a timely application for reemployment.

The time limits for returning to work are as follows:

- For less than 31 days of service – by the beginning of the first regularly scheduled work period after the end of the calendar day of duty, plus time required to return home safely and an eight hour rest period. If this is impossible or unreasonable through no fault of your own, then as soon as possible;
- For 31 to 180 days of service – you must apply for reemployment no later than 14 days after completion of military service. If this is impossible or unreasonable through no fault of your own, then as soon as possible;
- For 181 days or more of service – you must apply for reemployment no later than 90 days after completion of military service;
- For service-connected injury or illness – reporting or application deadlines are extended for up to two years if you are hospitalized or convalescing.

Aviso Importante:

Para obtener informacion o para someter una queja usted puede llamar al numero de telefono gratis de Blue Cross and Blue Shield of Illinois para informacion o para someter una queja al: 1-800-892-2803. Usted tambien puede escribir a Blue Cross and Blue Shield of Illinois al: P. O. Box 805107, Chicago, Illinois 60680-4112.

Administered by:



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.™

ASO-1

Effective Date: January 1, 2017
www.bcbsil.com

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Illinois provides administrative services only and
does not assume any financial risk or obligation with respect to claims.

EXHIBIT U



WELFARE BENEFITS PLAN

Summary Plan Description

2015

INTRODUCTION

This booklet is the Summary Plan Description (SPD) for the medical, prescription drug, dental, vision, critical illness insurance, flexible spending accounts, life and accident, disability, long-term care, commuter benefits, legal and employee assistance and pre-tax benefits offered under the Discover Financial Services Welfare Benefits Plan (“plan”) as in effect January 1, 2015. This SPD explains in easy-to-understand language the applicable terms of the plan. Additional SPDs and booklets are available for other benefits offered under the plan, including severance pay and change in control severance benefits. You should read this SPD carefully and keep it with your other important papers for future reference.

Discover Financial Services (“Discover”) sponsors the plan and reserves the right to amend the plan or discontinue the plan at any time in its sole discretion. The terms outlined in this SPD may change at any time but you will be provided with advanced written notice of any change and generally such changes will occur during annual enrollment held in the fall of each year.

We hope you find this information helpful to you and your family. If you have questions, you should contact myHR:

- **Online: resources.hewitt.com/discover**
Online service is generally available 24 hours a day, 7 days a week
- **Phone: 844-DFS-myHR (844-337-6947)**
You may contact a myHR Service Center Representative by phone from 8 a.m. to 6 p.m. Central Time, Monday through Friday, except certain holidays.

There is a great deal of plan information available to you through myHR. Once you become eligible to participate in the plan, visit the myHR website or call a myHR Service Center Representative to enroll, name a beneficiary and make or change benefit elections. After you have begun participating, refer back regularly to **www.mydiscoverbenefits.com** and myHR for updated information, including annual enrollment materials and other summaries of material modification and other important notices regarding the plan and administration. If you do not have access to the Internet, you may obtain access to all of this information by calling a myHR Service Center Representative.

The plan provides eligible employees of Discover and its participating affiliates and, in certain cases, their eligible dependents with welfare benefits under several different programs offered from time to time (“programs”). This SPD summarizes some of the benefits provided under the plan, as noted above. Other benefits provided under the plan are summarized in other SPDs. This booklet and certain other documents, including such other SPDs, any applicable insurance contracts, and any other applicable plan documents are incorporated into and are a part of the official plan documents. If there is any conflict between the information in the plan documents and any other materials, including any verbal representation, the plan documents control.

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ELIGIBILITY

You and your eligible dependents may participate in the plan if you are a U.S. benefits-eligible employee of Discover and are classified by Discover and its affiliates as:

- A full-time employee
- A flex part-time employee
- A regular part-time employee
- A fixed-term employee
- An employee working in Hawaii 20 hours or more per week for four consecutive weeks earning at least 86.67 times the current minimum wage a month, subject to Hawaii Department of Labor regulations, or
- A former retiree who was covered under the Discover Financial Services Retiree Welfare Benefits Plan ("Retiree Welfare Benefits Plan") on the day before being rehired as a full-time, flex part-time or regular part-time employee and is regularly scheduled to work more than 10 hours per week (more than 20 hours a week for business travel accident (BTA) insurance and accidental death and dismemberment (AD&D) insurance).

A U.S. benefits-eligible employee means an employee of Discover or a participating U.S. subsidiary who is eligible to participate in the plan and who either:

- Lives in the U.S., or
- Is a U.S. expatriate or U.S. benefits-eligible international employee who in either case receives pay from a U.S. dollar-based payroll

A listing of participating companies as of January 1, 2015, is found in the Other Important Information section of this SPD. An updated listing may be obtained from the plan administrator.

The determination of whether an individual is a U.S. benefits-eligible employee shall be made by the plan administrator in its sole discretion; provided such individuals who are employees of Discover or its participating affiliates are eligible to participate in the wellness and the employee assistance benefits under the Live and Work Well Program.

Employees who are classified by Discover and its affiliates as part-time, prime-time or temporary employees are not eligible to participate in the plan. Discover classifies employees under the Discover Financial Services Employee Classification Policy.

Additionally, individuals who are (a) classified by Discover and its affiliates as non-U.S. benefits-eligible workers, including, but not limited to, interns, summer associates, contingent workers, leased workers, independent contractors or consultants, regardless of whether or not such classification is subsequently upheld for any purpose by a court or federal, state or local administrative authority; (b) covered by a collective bargaining agreement with respect to which Discover or an affiliate is a party, unless such agreement provides for participation in the plan; or (c) hired in connection with an acquisition agreement entered into on or after January 1, 2008, unless such agreement provides for participation in the plan, are not eligible to participate in the plan.

Dependent Eligibility

Eligible dependents include:

- Your spouse or your domestic partner (see the Domestic Partnership Eligibility section for important information about domestic partner benefits)
- Your or your spouse's/domestic partner's eligible dependent children up to the end of the month in which they become age 26, regardless of marital status, eligibility for other coverage, or financial dependence on the parent
- Your or your spouse's/domestic partner's fully handicapped children

These dependent eligibility rules are not a guarantee of dependent coverage. The plan administrator has complete discretionary authority for determining dependent eligibility based on the plan's coverage rules.

Your or your spouse's/domestic partner's dependent children must live with you, and you or your spouse/domestic partner must be primarily responsible for their support. In the event of divorce, your dependent children may be eligible even if they do not live with you, provided the dependent is in the custody of one or both parents during the year and receives over one-half of his or her support from both parents and the custodial parent signs a written declaration that he or she will not claim the child as a dependent.

Alternatively in the event of divorce, your dependent children may be eligible even if they don't live with you and the custodial parent does not sign a written declaration if more than one-half of the child's support for the year is provided by the child's parents and the child is in the custody of one or both parents for more than one-half of the year, and the child qualifies as a tax dependent of one of the child's parents under Section 152(c) of the Internal Revenue Code.

The plan administrator reserves the right to request proof of dependent status upon enrollment or at any time while covering a dependent. Your children include your biological children, stepchildren, domestic partner's children, legally adopted children, children placed for adoption, foster children, children for whom you are the legal guardian, children you have legal custody of, children whom you may claim as a tax exemption as a non-custodial parent, or children you have an obligation to cover under a Qualified Medical Child Support Order (QMCSO).

Children born to your eligible dependent children are not eligible dependents unless you have legal custody. Parents, grandparents, and siblings are not eligible dependents. Certain participating programs have different eligibility terms for dependents as described in detail in this SPD, including the flexible spending accounts.

Qualified Medical Child Support Orders

A Medical Child Support Order (MCSO) is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or an administrative agency pursuant to a state domestic relations law that:

- Provides for child support or health benefit coverage (medical, dental and vision) for the child of an eligible participant in a group health plan relating to benefits under the group health plan, or
- Enforces a law concerning medical child support under a group health plan (medical, dental and vision) as provided by state Medicaid laws

An MCSO can only apply to an employee's children. The plan administrator, in its sole discretion, determines whether an MCSO meets the requirements of a Qualified Medical Child Support Order (QMCSO) pursuant to the plan's QMCSO procedures. The plan administrator may retain the services of a third party to administer QMCSOs on behalf of the plan.

Discover's procedures for obtaining a QMCSO and a sample QMCSO are available on the myHR website. Paper copies will be provided without charge to employees and dependents upon request to myHR.

A QMCSO can require health coverage (medical, dental and vision) even if the eligible employee does not have legal custody of the child. A child who receives benefits under a QMCSO is known as an alternate recipient. Children eligible for benefits under a QMCSO include any children who would be eligible dependents under the terms of the medical program as if the employee had legal custody. A QMCSO may not provide coverage for former spouses, domestic partners or the dependents of domestic partners.

If the plan receives a valid QMCSO, the employee and all relevant parties will be notified by the plan administrator or its delegate. An employee who is responsible for providing benefits to a child under the terms of a QMCSO may change his/her coverage election as necessary to comply with the requirements of the QMCSO (see the "Qualified Life Events" section).

Definition of Fully Handicapped

For purposes of medical, dental, vision, flexible spending accounts, legal plan and supplemental life insurance, a child is fully handicapped if:

- He/she is not able to earn his/her own living because of a mental or physical handicap which started prior to the date he/she reached the maximum age for eligibility as a dependent (age 26), and
- He/she depends primarily on you or another care provider for support

Another care provider means the child requires a community integrated living arrangement, group home, supervised apartment or other residential services licensed or certified by a state department of health. Proof that your child is fully handicapped must be submitted to the plan administrator (or designated third party which currently is the national medical plan provider) within 31 days after the child reaches the plan's maximum age. Each program has the right to require proof of the continuation of the handicap from time to time. At that time, the program is required to obtain verification of handicapped status through myHR. If needed, myHR will coordinate the verification with the national medical plan provider.

Coverage will cease on the first to occur:

- Cessation of the handicap or dependency
- 60-days after proof of the continuation of the handicap or dependency has been requested but not provided, or
- Termination of dependent coverage for any reason other than reaching maximum age

The plan administrator (or designated third party which currently is the national medical plan provider) has the sole discretionary authority for determining whether your child qualifies as a handicapped dependent.

Domestic Partnership Eligibility

All references to domestic partner or civil union partner in this document are defined as follows:

A domestic partner (of either gender) or civil union partner is considered eligible if you and your partner are engaged in a spouse-like relationship and your relationship meets one of the following criteria:

- You and your domestic partner or civil union partner are registered as domestic partners through a governmental domestic partnership or civil union partnership registry, or
- You and your domestic partner or civil union partner are registered through myHR

For your domestic partner or civil union partner to be registered through myHR, your relationship must meet the following criteria:

- You have shared a primary residence for at least six months and are responsible to each other for the direction and management of your household
- You are both legally entitled to reside in your household under applicable immigration laws
- You have a committed relationship of mutual caring which has existed for at least six months prior to enrollment in Discover's benefit plans
- Your relationship is expected to be long-term
- You are both 18 years of age or older and mentally competent
- Neither you nor your domestic partner or civil union partner is married or has another domestic partner or civil union partner
- You are not blood relatives
- You have not been married to each other at any time within the past 12 months

If your domestic partner and his/her eligible dependents qualify as your dependents under federal tax law, you pay for their coverage under the medical, dental and vision programs with pre-tax dollars. See IRS Publication 502 to determine whether your domestic partner and his/her children may qualify as your dependents under federal income tax rules. You must return a Domestic Partnership Registration

Form to myHR, indicating their federal tax dependent status to avoid imputed income. Registration forms are available through myHR.

If your domestic partner or civil union partner and his/her eligible dependents are not your tax dependents under federal tax law, the full cost of medical or dental coverage for these dependents is taxable to you under federal tax law, and, therefore, added to your taxable income and reported on your Form W-2 as imputed income. Imputed income is added to your income on each pay date and you are responsible for the resulting tax on the imputed income. You are responsible for determining the tax dependent status of your dependents under federal tax law.

If your domestic partner or civil union partner relationship status changes (for example, marriage, divorce, or termination of partnership or civil union), you must contact myHR within 31 days of the change in status to update your dependents on file and to avoid imputed income (if applicable).

If your domestic partner or civil union partner (and his/her eligible dependents) is your dependent under state tax law, contact myHR.

Other Important Dependent Eligibility Information

A person is determined to be a spouse or surviving spouse if the individual is lawfully married to an eligible employee under the laws of any domestic or foreign jurisdiction where such individual and employee were married.

Other than under the life and accident insurance programs, no person may be covered both as an employee and a dependent; no person may be covered as a dependent of more than one employee.

Discover audits on a regular and/or periodic basis the coverage of dependents, including spouses, domestic partners, civil union partners and children to ensure compliance with plan rules. Any person who fails to cooperate or who provides false or misleading information to Discover or the plan for the purpose of obtaining benefits may lose any or all benefits coverage and will be required to repay any benefits improperly received. Employees may be subject to further corrective action, up to and including termination of employment and forfeiture of executive compensation.

ENROLLMENT

As a new or newly benefits-eligible active employee, you may elect coverage under the plan within 31 days of the date your personalized enrollment materials are produced and sent to you (but not after November 1 for the FSA).

Enrollment is available on myHR when newly eligible, with a qualified life event that allows enrollment, or during annual enrollment held in the fall of each year.

The elections you make are generally effective from your first day of employment, or the first day of benefits eligibility, whichever is later. Life insurance coverage is generally effective the date of enrollment. The insured must be living at the time of enrollment. You must timely enroll new dependents (within 31 days) in order for them to be covered. Once enrolled, the corresponding payroll deduction change is effective as of your new hire date or newly eligible date, whichever is later.

You will be required to provide eligible dependent(s)' social security numbers when adding them to coverage.

If you do not make elections through myHR during your initial eligibility enrollment period, you will be enrolled in the following coverage automatically:

- Medical coverage for yourself only in the HRA plan, including Basic Critical Illness
- Short-Term Disability (STD)
- Long-Term Disability (LTD)
- Basic life insurance (1 times your HWEE, (see the "Health and Welfare Eligible Earnings" section for more information) up to \$500,000)
- Basic Accidental Death and Dismemberment (AD&D) Insurance (1 times your HWEE, up to \$500,000)
- Business Travel Accident (BTA) insurance

You may change your coverage elections, including your dependents, during annual enrollment, held each fall for coverage in the following calendar year, or within 31 days of a Qualified Life Event (QLE) (see the "QLE" section for more information).

Evidence of Insurability (EOI) may be required for some elections. Coverage requiring EOI will become effective the later of the date the EOI is found satisfactory, or the general effective date for the enrollment period (for example, annual enrollment elections become effective January 1, or the date the required EOI approved, if later).

If you do not make changes based on a QLE, your coverage except for the FSA will continue as in effect from year to year. To continue to participate in the FSA you must re-enroll annually during annual enrollment. To drop coverage, other than FSA, you must elect no coverage during annual enrollment.

Additional LTD Enrollment Information

If you waive LTD coverage and wish to elect coverage at a later date, you will be required to provide Evidence of Insurability (EOI) to CIGNA.

Under the LTD program, the "active at work" rule applies. If you are ill or injured and away from work on the day your coverage would become effective, the effective date of coverage and any premium will be deferred to the date you return to work for one full day.

Additional FSA and HSA Enrollment Information

If you were hired on or after November 1, you cannot enroll in a Health Care FSA or Dependent Care FSA for the remainder of that year. However, during annual enrollment you can enroll in either or both FSAs for the following year. See the "Flexible Spending Accounts" section for details.

If you leave Discover, your participation in the Health Care FSA will end on the last day of the month of your termination unless you elect to continue the Health Care FSA through COBRA. See the "COBRA" section for details.

If you were hired on or after December 1, you can enroll in a HSA; however your account will not be opened until January 1 of the following year. If you leave Discover, your contributions to the HSA will end; however, you own your HSA and your account goes with you.

Additional Life and Accident Insurance Enrollment Information

If you elect supplemental life insurance coverage at any time after your initial 31-day enrollment period, or if you elect coverage greater than the guaranteed issue amount, you will be required to provide medical evidence of good health (see the "Life and Accident Insurance" section) for yourself and your spouse or domestic partner. Coverage that requires EOI will become effective the later of the date the EOI is found satisfactory, or the general effective date of the enrollment. EOI is not required for eligible dependent children.

To elect supplemental life insurance coverage for your spouse or domestic partner or eligible dependent children, you must also elect supplemental life insurance coverage for yourself. In addition, the amount of supplemental life insurance coverage for your spouse, domestic partner, or dependent children cannot exceed the supplemental life insurance coverage you elect for yourself.

Under the life and accident insurance programs, a person may be covered both as an employee and a dependent; a child may be covered as a dependent of more than one employee.

You may elect to increase your and your spouse's or domestic partner's supplemental life insurance coverage by one level each year during annual enrollment without providing EOI, as long as the resulting coverage amount elected is less than or equal to \$1,000,000 for yourself or \$30,000 for your spouse or domestic partner. If you elect an increase in coverage that will result in a coverage amount in excess of \$1,000,000 for yourself or \$30,000 for your spouse or domestic partner or you elect to increase your or your spouse's/domestic partner's coverage by more than one level, you or your spouse or domestic partner will be required to provide EOI. EOI is always required if you previously waived coverage. Evidence of insurability will be required for any increase for an insured who was previously declined coverage due to failure to provide satisfactory evidence of insurability.

Under the life and accident insurance program the "active at work" rule applies. If you are ill or injured and away from work on the day your coverage (or any increase in coverage) would become effective, the effective date of coverage (or increase) and any increase in premium will be deferred (for yourself and eligible dependents) to the date you return to work for one full day. As an exception, coverage provided under the 31-day child automatic coverage from live birth provision applicable to an employee's first eligible newborn child is not subject to the "active at work" rule.

Dependent life coverage is also subject to a "non-confinement" rule. If a dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement (this does not apply to a newborn child).

Coverage Levels

You may choose one of the following coverage levels for medical, dental, vision, and life and accident programs:

- No Coverage (does not apply to basic life insurance coverage which is automatic)
- Yourself Only
- Yourself plus Spouse/Domestic Partner
- Yourself plus Children (does not include spouse/ domestic partner)
- Yourself plus Family (spouse/domestic partner plus children)

You may elect "coverage" or "no coverage" for the legal and LTD programs.

If you elect "coverage" under the legal assistance program, all eligible family members (spouse/ domestic partner, dependents) will be eligible to access the program.

If you cover eligible dependents, you must identify each dependent during the enrollment process.

QUALIFIED LIFE EVENTS

As a general rule, elections concerning coverage under the plan's various benefit programs are irrevocable for the entire calendar year. However, you may change your elections in limited circumstances, known as Qualified Life Events (QLEs) provided that you contact myHR within 31 days of the QLE.

If you have a child born or adopt a child, the child will be presumed to be covered for the medical, dental and vision programs, if elected, so long as you are enrolled in You + Family coverage, and you add the child as a covered dependent within ninety (90) days of birth or adoption by contacting myHR.

For any coverage category other than You + Family, if you have a child born or adopt a child, the child may be enrolled in the medical, dental and vision programs, if elected, so long as you notify myHR within 31 days of the birth or adoption. If you fail to notify myHR within 31 days, you may still be able to add the child as a covered dependent if you file a claim requesting such coverage to the claims committee within 90 days of the birth or adoption, by contacting myHR.

Also, if you or your dependent loses eligibility for Medicaid or coverage under a State Children's Health Insurance Program (SCHIP), or if you or your dependent becomes eligible for a state premium assistance subsidy under the plan through Medicaid or SCHIP, you must request special enrollment under these circumstances from myHR within 60 days after the termination of coverage or the determination of eligibility for a state premium assistance subsidy, as applicable.

If you want to make any changes in coverage elections due to QLEs, new dependents or requests for special enrollment or obtain more information, please contact myHR.

In general, QLEs are events that affect you or your spouse's legal marital status, number of dependents, employment status, and certain plan cost or coverage changes (determined by the plan administrator).

If you drop or decline LTD coverage and, at a later date, elect to be covered, the EOI requirements will apply to your later coverage election.

If you drop or decline life insurance coverage and at a later date elect to be covered, increase your coverage level more than one level, or choose a coverage amount that results in a supplemental insurance amount of \$1,000,000 for yourself or over \$30,000 for your spouse/domestic partner, the EOI requirements will apply to your later coverage election.

- **Consistency Rule:** You may only change your elections in a manner consistent with your QLE. For instance, if you acquire a dependent through birth, adoption or marriage, you may add medical coverage for your dependent. Conversely, if your dependent no longer qualifies for coverage, you may drop the dependent.
- **Domestic Partners:** You may enroll your domestic partner in the plan within 31 days of the date you first meet the criteria listed in the Domestic Partnership Eligibility section (except for the FSA). See the "Flexible Spending Accounts" section for details. Under IRS rules, the health care or dependent day care expenses of your domestic partner or your domestic partner's dependents generally cannot be reimbursed under the FSA program, unless they are your dependents as determined under federal tax law. You are responsible for determining whether your dependents are dependents under applicable tax law. Contact ConnectYourCare for details.

Generally, your coverage election changes for a QLE are effective the date the QLE occurred. The corresponding payroll deduction changes are effective as of the paycheck date following the date you make your new election through myHR. If you increase your FSA contribution election during the plan year due to a QLE, only FSA expenses incurred on or after the QLE are eligible for reimbursement from the additional amount. If you decrease your FSA contribution election during the plan year due to a QLE, you may only decrease it at least to the amount already contributed.

Important Information About Dependent Coverage

If your dependent becomes ineligible for coverage, you must notify myHR of the dependent's loss of eligibility within 31 days of the event (for example, date of divorce). In addition, if your dependent is eligible for COBRA continuation coverage, you must notify myHR within 60 days of the date of the qualifying event. Regardless of when you notify myHR, your dependent's coverage will end retroactive to the last day of the month in which the dependent ceased to meet the dependent eligibility requirements.

Qualified Life Events

A qualified life event includes the occurrence of any of the events in the following table. See the "Qualified Life Events" notes section after this table for other important information.

TYPE OF QUALIFIED LIFE EVENT		
MARRIAGE	ADDITION OF DEPENDENT	DIVORCE, LEGAL SEPARATION OR ANNULMENT
MEDICAL, DENTAL AND VISION BENEFITS		
Increase coverage level	Increase coverage level	Decrease coverage level
If no coverage, may elect coverage for yourself, spouse and/or eligible dependents	If no coverage, may elect coverage for yourself, spouse and/or eligible dependents	May elect coverage for yourself and/or eligible dependents (if coverage is lost under spouse's plan)
Drop coverage if enrolled in spouse's plan	Change plan option	Change plan option
Change plan option		
HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA)		
Start or increase contributions	Start or increase contributions	Start or increase contributions if employee or dependents no longer covered by spouse's dependents (if coverage is lost under spouse's plan)
Stop or decrease contributions if employee becomes covered by spouse's health plan		Stop or decrease contributions
DEPENDENT DAY CARE FLEXIBLE SPENDING ACCOUNT (DDCFSA)		
Start or increase contributions if you acquire a dependent	Start or increase contributions	Start or increase contributions if spouse is no longer the primary caregiver and cost of care increases
Stop or decrease contributions if spouse will take over child care		Stop or decrease contributions

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TYPE OF QUALIFIED LIFE EVENT		
MARRIAGE	ADDITION OF DEPENDENT	DIVORCE, LEGAL SEPARATION OR ANNULMENT
LONG-TERM DISABILITY (LTD) AND LEGAL ASSISTANCE		
If no coverage, may elect coverage	If no coverage, may elect coverage	If no coverage, may elect coverage
Drop coverage if enrolled in spouse's plan		Drop coverage
LIFE AND ACCIDENT INSURANCE (MAY BE SUBJECT TO EVIDENCE OF INSURABILITY [EOI]; SEE EOI SECTION)		
Increase coverage level	Increase coverage level	Decrease coverage level
If no coverage, may elect coverage for yourself, spouse and/or eligible dependents	If no coverage, may elect coverage for yourself, spouse and/or eligible dependents	May elect coverage for yourself and/or eligible dependents (if coverage is lost under spouse's plan)
Drop coverage if enrolled in spouse's plan		
CRITICAL ILLNESS INSURANCE		
If no coverage, may elect coverage	If no coverage, may elect coverage	If no coverage, may elect coverage
Drop coverage	Drop coverage	Drop coverage
DEATH OF SPOUSE OR DEPENDENT	SPOUSE'S EMPLOYMENT STATUS CHANGE (change of spouse's or dependent's health plan coverage, causing gain or loss of benefits)	DEPENDENT LOSS OF ELIGIBILITY (age or student status)
MEDICAL, DENTAL AND VISION BENEFITS		
Change coverage level	Change coverage level	Decrease coverage level
May elect coverage for yourself and/or eligible dependents (if coverage is lost under spouse's plan)	If no coverage, may elect coverage for yourself, spouse and/or eligible dependents	
Change plan option	Drop coverage (if you, your spouse or dependents gain or lose coverage under a new plan)	
	Change plan option	
HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFA)		
Start or increase contributions if employee or dependents no longer covered by spouse's health plan	Start or increase contributions if cost changes	Stop or decrease contributions
Stop or decrease contributions	Stop or decrease contributions if plan coverage begins	

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TYPE OF QUALIFIED LIFE EVENT		
DEATH OF SPOUSE OR DEPENDENT	SPOUSE'S EMPLOYMENT STATUS CHANGE (change of spouse's or dependent's health plan coverage, causing gain or loss of benefits)	DEPENDENT LOSS OF ELIGIBILITY (age or student status)
DEPENDENT DAY CARE FLEXIBLE SPENDING ACCOUNT (DDCFSA)		
Stop or decrease contributions if dependent child will no longer reside with employee	Start or increase contributions if cost changes	Change or stop contribution if last qualified dependent turns age 13
Start or increase contributions if cost changes	Stop or decrease contributions if cost changes	
LONG-TERM DISABILITY (LTD) AND LEGAL ASSISTANCE		
If no coverage, may elect coverage	If no coverage, may elect coverage	N/A for LTD
Drop coverage	Drop coverage	N/A for Legal Assistance Plan
LIFE AND ACCIDENT INSURANCE (MAY BE SUBJECT TO EVIDENCE OF INSURABILITY [EOI]; SEE EOI SECTION)		
Change coverage level	Change coverage level	Decrease coverage level
	If no coverage, may elect coverage for yourself, spouse and/or eligible dependents	
	Drop coverage (if you, your spouse or dependents gain or lose coverage under spouse's plan)	
CRITICAL ILLNESS INSURANCE		
If no coverage, may elect coverage	Drop coverage	Drop coverage
Drop coverage		
RE-EMPLOYMENT	UNPAID LEAVE OF ABSENCE	RETURN FROM UNPAID LEAVE
MEDICAL, DENTAL AND VISION BENEFITS		
Reinstate prior coverage if rehired within 31 days of termination and within the same calendar year	Drop coverage	Reinstate prior coverage dropped* if you return from Leave within 31 days and within the same calendar year *If dropped due to non-payment, automatically reinstated. If dropped by request, then must elect to reinstate upon return from leave.
Any change permitted if rehired after 31 days or in a subsequent calendar year		Any change permitted if after 31 days or in a subsequent calendar year

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TYPE OF QUALIFIED LIFE EVENT		
RE-EMPLOYMENT	UNPAID LEAVE OF ABSENCE	RETURN FROM UNPAID LEAVE
HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA)		
Reinstate prior goal amount if rehired within 31 days of termination, within the same calendar year and prior to November 1	Stop or decrease coverage	Reinstate prior goal amount stopped or decreased if you return from leave within 31 days, within the same calendar year and prior to November 1
Any change permitted if rehired after 31 days or in a subsequent calendar year		Any change permitted if after 31 days or in a subsequent calendar year
DEPENDENT DAY CARE FLEXIBLE SPENDING ACCOUNT (DDCFSA)		
Reinstate prior goal amount if rehired within 31 days of termination and within the same calendar year and prior to December 15	Start or increase contributions if you acquire a dependent	Reinstate prior coverage if you return from leave within 31 days and within the same calendar year
Any change permitted if rehired after 31 days or in a subsequent calendar year		Any change if you return after 31 days or in subsequent calendar year
LONG-TERM DISABILITY (LTD) AND LEGAL ASSISTANCE		
Reinstate coverage if rehired within 31 days of termination and within the same calendar year	Drop coverage	Reinstate coverage if you return from leave within 31 days and within the same calendar year
Any change permitted if rehired after 31 days or in a subsequent calendar year		Any change if you return after 31 days or in subsequent calendar year
LIFE AND ACCIDENT INSURANCE (MAY BE SUBJECT TO EVIDENCE OF INSURABILITY [EOI]; SEE EOI SECTION)		
Reinstate prior coverage if rehired within 31 days of termination and within the same calendar year	Drop coverage	Reinstate prior coverage if you return from Leave within 31 days and within the same calendar year
Any change permitted if rehired after 31 days or in a subsequent calendar year		Any change if you return after 31 days or in subsequent calendar year
PAID LEAVE OF ABSENCE		RETURN FROM PAID LEAVE OF ABSENCE
MEDICAL, DENTAL AND VISION BENEFITS		
Drop coverage	Reinstate prior coverage dropped* if you return from leave within 31 days and within the same calendar year *If dropped due to non-payment automatically reinstated. If dropped by request, then must elect to reinstate upon return from leave.	
	Any change permitted if done after 31 days or in a subsequent calendar year	

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TYPE OF QUALIFIED LIFE EVENT			
PAID LEAVE OF ABSENCE		RETURN FROM PAID LEAVE OF ABSENCE	
HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA)			
Stop or decrease coverage		Reinstate prior goal amount stopped or decreased if you return from leave within 31 days, within the same calendar year and prior to November 1	
		Any change permitted if done after 31 days or in a subsequent calendar year	
DEPENDENT DAY CARE FLEXIBLE SPENDING ACCOUNT (DDCFSA)			
Start or increase contributions if you acquire a dependent		Reinstate price goal amount if you return from leave within 31 days and within the same calendar year	
		Any change permitted if after 31 days or in a subsequent calendar year	
LONG-TERM DISABILITY (LTD) AND LEGAL ASSISTANCE			
N/A		N/A	
LIFE AND ACCIDENT INSURANCE (MAY BE SUBJECT TO EVIDENCE OF INSURABILITY [EOI]; SEE EOI SECTION)			
N/A		N/A	
CRITICAL ILLNESS INSURANCE			
Drop coverage		Drop coverage	
TRANSFER TO INTERNATIONAL/ RETURN FROM INTERNATIONAL (EXPATRIATE OR SHORT-TERM ASSIGNMENT)	QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)	LOSS OF OTHER HEALTH COVERAGE	
MEDICAL, DENTAL AND VISION BENEFITS			
Increase coverage level for yourself, spouse and/or eligible dependents	Allow participant to comply with order	Increase coverage level	
If no coverage, may elect coverage for yourself, spouse and/or eligible dependents		May elect coverage for yourself, spouse and/or eligible dependents	
Drop coverage if enrolled in spouse's plan		Change plan option	
HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA)			
Start or increase contributions	Start or increase contributions	Start or increase contributions	
Stop or decrease contributions			
DEPENDENT DAY CARE FLEXIBLE SPENDING ACCOUNT (DDCFSA)			
Start or increase contributions	N/A	Start or increase contributions	
Stop of decrease contributions			
LONG-TERM DISABILITY (LTD) AND LEGAL ASSISTANCE			
If no coverage, may elect coverage	If no coverage, may elect coverage	N/A	

Continued on next page.

TYPE OF QUALIFIED LIFE EVENT		
TRANSFER TO INTERNATIONAL/ RETURN FROM INTERNATIONAL (EXPATRIATE OR SHORT-TERM ASSIGNMENT)	QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)	LOSS OF OTHER HEALTH COVERAGE
LIFE AND ACCIDENT INSURANCE (MAY BE SUBJECT TO EVIDENCE OF INSURABILITY [EOI]; SEE EOI SECTION)		
Increase coverage level for yourself, spouse and/or eligible dependents	N/A	N/A
If no coverage, may elect coverage for yourself, spouse and/or eligible dependents		
CRITICAL ILLNESS INSURANCE		
Drop coverage	Drop coverage	Drop coverage
ENTER INTO A DOMESTIC PARTNERSHIP		DISSOLUTION OF A DOMESTIC PARTNERSHIP
MEDICAL, DENTAL AND VISION BENEFITS		
Increase coverage level	Decrease coverage level	
If no coverage, may elect coverage for yourself, partner and/or eligible dependents	May elect coverage for yourself and/or eligible dependents (if coverage is lost under spouse’s plan)	
HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFA)		
N/A	N/A	
DEPENDENT DAY CARE FLEXIBLE SPENDING ACCOUNT (DDCFA)		
Start or increase contributions if you acquire a dependent	Start or increase contributions if partner is no longer the primary caregiver and cost of care increases	
Stop or decrease contributions if partner will take over child care	Stop or decrease contributions	
LONG-TERM DISABILITY (LTD) AND LEGAL ASSISTANCE		
If no coverage, may elect coverage	If no coverage, may elect coverage	
Drop coverage if enrolled in domestic partner’s plan	Drop coverage	
LIFE AND ACCIDENT INSURANCE (MAY BE SUBJECT TO EVIDENCE OF INSURABILITY [EOI]; SEE EOI SECTION)		
Increase coverage level	Increase coverage level	
If no coverage, may elect coverage for yourself, partner and/or eligible dependents	Decrease coverage level	
Drop coverage if enrolled in domestic partner’s plan	May elect coverage for yourself and/or eligible dependents (if coverage is lost under domestic partner’s plan)	
CRITICAL ILLNESS INSURANCE		
If no coverage, may elect coverage	If no coverage, may elect coverage	
Drop coverage	Drop coverage	
FULL TIME TO REGULAR PART TIME/FLEX PART TIME		REGULAR PART TIME/FLEX PART TIME TO FULL TIME
MEDICAL, DENTAL AND VISION BENEFITS		
Increase or decrease coverage level	Increase or decrease coverage level	
Drop coverage if enrolled in spouse’s plan	May elect coverage for yourself and/or eligible dependents (if coverage is lost under spouse’s plan)	
Change plan option	Change plan option	

Continued on next page.

TYPE OF QUALIFIED LIFE EVENT	
FULL TIME TO REGULAR PART TIME/FLEX PART TIME	REGULAR PART TIME/FLEX PART TIME TO FULL TIME
HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA)	
N/A	N/A
DEPENDENT DAY CARE FLEXIBLE SPENDING ACCOUNT (DDCFSA)	
Start or increase contributions	Start or increase contributions
Stop or decrease contributions	Stop or decrease contributions
LONG-TERM DISABILITY (LTD) AND LEGAL ASSISTANCE	
N/A	N/A
LIFE AND ACCIDENT INSURANCE (MAY BE SUBJECT TO EVIDENCE OF INSURABILITY [EOI]; SEE EOI SECTION)	
N/A	N/A
CRITICAL ILLNESS INSURANCE	
Drop coverage	Drop coverage
GAIN ELIGIBILITY FOR ASSISTANCE UNDER CHIP OR MEDICAID	LOSS OF ELIGIBILITY FOR ASSISTANCE UNDER CHIP OR MEDICAID
MEDICAL, DENTAL AND VISION BENEFITS	
Increase coverage level (medical only)	May elect coverage for yourself and/or eligible dependents (medical only)
If no coverage, may elect coverage for yourself, spouse and/or eligible dependents (medical only)	
Drop coverage	
Change plan option (medical only)	
HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA)	
Stop or decrease contributions	Start or increase contributions
DEPENDENT DAY CARE FLEXIBLE SPENDING ACCOUNT (DDCFSA)	
N/A	N/A
LONG-TERM DISABILITY (LTD) AND LEGAL ASSISTANCE	
N/A	N/A
LIFE AND ACCIDENT INSURANCE (MAY BE SUBJECT TO EVIDENCE OF INSURABILITY [EOI]; SEE EOI SECTION)	
N/A	N/A
CRITICAL ILLNESS INSURANCE	
Drop coverage	Drop coverage

CONTINUATION OF COVERAGE DURING WORK OR LIFE EVENTS

If you or a covered dependent experiences a specific work or life event, the continuation of your benefits may be affected. The following pages describe the impact of different life events on your welfare benefits.

Note: IRS rules dictate what changes are allowable due to certain qualified life events. See the “Qualified Life Events” section for details.

REHIRE

Impact on Your Medical, Dental, Vision, Life, Accident, Critical Illness, Long-Term Disability (LTD), HSA and Legal Assistance Benefits

If your rehire date is within 31 days of termination and in the same calendar year, coverage prior to your termination is reinstated (no EOI will be required for LTD and life and accident insurance).

If your rehire date is more than 31 days after termination or in a new calendar year, you may make a new election within 31 days of your rehire date.¹

Impact on Your Flexible Spending Account (FSA) Benefits

If your rehire date is within 31 days of termination, in the same calendar year and prior to November 1, the annual contribution amount you elected to be contributed to an FSA account prior to your termination is reinstated.

If your rehire date is more than 31 days after termination or in a new calendar year, you may make new elections within 31 days of your rehire date, provided you make your election prior to November 1.²

You may only receive reimbursement from your Health Care FSA (HCFSAs) for eligible expenses incurred while you were actively employed by Discover and were contributing to your account through December 31, unless you elect to continue HCFSAs coverage through COBRA during your break in service.

TERMINATE, RETIRE OR BECOME INELIGIBLE FOR BENEFITS

Impact on Your Medical, Dental, Vision, Life, Accident, Critical Illness and Legal Assistance Benefits

Coverage under the active medical, dental, vision and critical illness programs ceases at the end of the month of your termination, retirement or loss of eligibility date, unless you are eligible for retiree medical coverage. See the “Retiree Welfare Benefits Summary Plan Description” for details on retiree medical coverage and eligibility.

You may continue your active medical, dental and vision coverage at your own expense, generally, for up to 18 months through COBRA. See the “Continuation Coverage Rights Under COBRA” section for details.

The legal assistance program will cover eligible legal fees for covered services that were open and pending prior to your termination, retirement or loss of eligibility date. You may be eligible to continue coverage at your own expense for 24 months. See the “Legal Assistance Program” section.

For life and accident insurance, see the Terminate, Retire or Become Ineligible for Benefits-Life and Accident Insurance section.

You will be directly billed by myHR, the benefits administrator, for the cost of coverage under COBRA or in retirement.

¹ If you do not make a timely election, your coverage will default automatically to: Your Only coverage in the Blue Cross Blue Shield HRA medical plan option or HMSA medical plan option, LTD coverage and no coverage under dental, vision or legal.

² If you do not make a timely election, you will not be permitted to contribute to an FSA account for the remainder of the calendar year.

Impact on Your Flexible Spending Account (FSA) Benefits

FSA coverage ceases as of your termination, retirement or loss of eligibility. If you have a balance remaining in your HCFSAs, you can only submit claims for reimbursement that were incurred prior to your termination, retirement, or loss of eligibility date. FSA coverage does not continue to the end of the month. Eligible expenses may be submitted up to March 31 of the following year. You may continue your HCFSAs coverage through COBRA on an after-tax basis until the end of the calendar year and submit expenses incurred after your termination, retirement, or loss of eligibility for reimbursement.

If you have a balance remaining in your Dependent Day Care FSA (DDCFSA), you may request reimbursement for eligible expenses up to March 31 of the following year for expenses incurred through the end of the calendar year. COBRA continuation is not available, nor necessary, for the DDCFSA. Keep in mind that eligible expenses are those that allow you to work, be a full-time student, or if you are disabled, to care for your dependents.

Impact on Your Long-Term Disability (LTD) Benefits

Coverage ceases as your termination, retirement or loss of eligibility date. A “conversion privilege” is available if you leave Discover and are under the age of 70, with the exception of retirement or disability, if you are no longer eligible for coverage. Under the conversion privilege, you may be able to convert a portion of your group LTD coverage to an individual insurance policy without providing medical EOI, if you apply within the first 31 days following termination or loss of coverage. To be eligible for conversion you must have been insured through LTD coverage for at least 12 consecutive months prior to the date your group insurance terminated under this program. The conversion coverage must be applied for within 62 days following termination or loss of coverage, but if application is made between 31 and 62 days, EOI needs to be submitted. Conversion rates are based on your age and may differ from the rates provided under the Discover disability program. Contact myHR for conversion application forms and CIGNA for rate information.

PAID LEAVE OF ABSENCE (includes Short-Term Disability)

Note: Beginning a paid leave generally constitutes a qualified life event. See the “Qualified Life Event” section for details. To make changes to coverage you must contact myHR within 31 days of the date that you begin your leave.

Impact on Your Medical, Dental, Vision, Life, Accident, Critical Illness, and Legal Assistance Benefits

Coverage continues through payroll deductions. Basic AD&D and BTA insurance terminates but automatically resumes upon your return from leave. If you incur claims under the medical, dental or vision programs while you are on a paid military leave and you are covered under both Discover’s plan and the U.S. Defense Department plan, the Discover plan is considered primary. See the “Coordination of Benefits” section. Upon your return from leave, you may participate in the plans on the same terms as prior to your leave if eligible.

Impact on Your Commuter Benefits

Coverage ceases upon leave of absence. You must re-enroll in the program upon return from leave.

Impact on Your Flexible Spending Account (FSA) Benefits

Coverage continues through payroll deductions.

Impact on Your Long-Term Disability (LTD) Benefits

Coverage continues through payroll deductions. Disabilities you incur during your paid or unpaid leave will be subject to the exclusions under the LTD program. See the “Long-Term Disability” section for details.

UNPAID LEAVE OF ABSENCE¹

Note: Beginning an unpaid leave generally constitutes a qualified life event. See the “Qualified Life Event” section for details. To make changes to coverage you must contact myHR within 31 days of the date you begin your leave.

Impact on Your Medical, Dental, Vision, Life, Accident, Critical Illness, and Legal Assistance Benefits

You may continue coverage (except basic AD&D and BTA). You will be billed monthly, on an after-tax basis, by myHR, the benefits administrator. If you fail to make after-tax payments, your coverage may be terminated during your unpaid leave.

Basic AD&D and BTA insurance coverage terminates but automatically resumes upon your return from leave.

Upon your return from leave, you may participate in the plans on the same terms as prior to your leave if eligible.

Impact on your Commuter Benefits

Commuter benefits coverage ceases upon leave of absence. You must re-enroll in commuter benefits upon return from leave.

Impact on Your Flexible Spending Account (FSA) Benefits

You may continue both HCFSAs and DDCFSAs coverage. You will be billed monthly, on an after-tax basis, from myHR.

If you do not continue HCFSAs coverage, expenses incurred while on leave (when you were not contributing to the HCFSAs) will not be eligible for reimbursement.

You may incur expenses for DDCFSAs coverage even while you are not contributing to the DDCFSAs.

Keep in mind that eligible expenses are those that allow you to work, be a full-time student, or if you are disabled, to care for your dependents.

Impact on Your Long-Term Disability (LTD) Benefits

You may continue LTD coverage for up to six months as long as premiums continue. After six months, coverage is dropped unless you remain on an approved Military Leave and then premiums continue.

DEATH

Impact on Your Medical, Dental, Vision, Life, Accident, Critical Illness, and Legal Assistance Benefits

If you were an active employee at the time of your death, medical, dental and vision coverage will continue for your covered dependents at the same coverage level as prior to your death for one year, at Discover's expense.

After one year of coverage at Discover, your covered dependents may continue medical, dental and vision coverage at their own expense through COBRA. See the “Continuation Coverage Rights Under COBRA” section for details.

Discover will pay a one-time special death benefit to the employee's designated life insurance beneficiary(ies). This amount is separate from any life insurance benefit and is equal to the greater of either one month in gross salary or \$2,000.

Life and accident coverage ceases on the date of your death. Any covered dependents may convert their supplemental life coverage to individual policies within 60 days from the date of your death. Contact Minnesota Life for more information.

Critical illness coverage ceases on the date of your death.

Legal assistance program participation and contributions cease on the date of your death. The program will cover eligible legal fees for covered services that were open and pending prior to your death.

¹ During unpaid leave, you will be billed on a monthly basis by myHR. If you do not make timely payments to myHR, your coverage will be cancelled. Note, during an unpaid personal leave, you will be billed 100% of the cost of your coverage. This means you are responsible for paying both your share of the cost and the Discover share of the cost of coverage.

Impact on Your Flexible Spending Account (FSA) Benefits

Your contributions to an FSA cease upon your death. Your eligible dependents may submit FSA claims for reimbursement up to March 31 of the following calendar year, for eligible expenses incurred prior to your death (for the HCFSAs) and eligible expenses incurred through the end of the calendar year (for the DDCFSAs). Keep in mind that eligible expenses are those that allow you to work, be a full-time student, or if you are disabled, to care for your dependents.

Impact on Your Long-Term Disability (LTD) Benefits

If you die while receiving a monthly disability benefit at the time of your death, CIGNA will pay a survivor income benefit when it receives proof satisfactory of your death, and that the person claiming the benefit is entitled to it. The survivor income benefit will only be paid to your surviving spouse, or if no surviving spouse, in equal shares to your surviving children. If there is no surviving spouse or surviving children, then benefits will be paid to the employee's estate. However, CIGNA will first apply the survivor Income Benefit to any overpayment, which may exist on your claim. The survivor income benefit is calculated as three times the lesser of: 1) your monthly income loss multiplied by the benefit percentage in effect on the date of your death or 2) the maximum monthly benefit.

DEPENDENT BECOMES INELIGIBLE FOR BENEFITS

Impact on Your Medical, Dental, Vision, Life, Accident, Critical Illness, and Legal Assistance Benefits

Coverage ceases on the last day of the month in which your dependent becomes ineligible for medical, dental and vision coverage. At this time, they may have the right to continue medical, dental and vision coverage at their own expense, generally for up to 36 months through COBRA, see the "Continuation Coverage Rights Under COBRA" section.

It is your responsibility to notify myHR within 60 days of the date that your dependent loses eligibility and ensure that myHR has the correct address on file for your dependent.

Your dependent may be able to convert life insurance coverage and port supplemental life insurance coverage, contingent on the employee porting as well. See the "Life and Accident Insurance" section for more information. Conversion and portability policies are not available for accident insurance coverage.

Critical illness coverage ceases for your dependents on the last day of the month in which your dependents reach the applicable age limit or when they no longer qualify as your eligible dependents for any other reason.

Legal assistance program coverage for your dependents ceases when they reach the applicable age limit or when they no longer qualify as your eligible dependents for any other reason.

Impact on Your Flexible Spending Account (FSA) Benefits

Coverage ceases on the day they reach the applicable age limit or when they no longer qualify as your eligible dependents for any other reason, such as divorce.

Impact on Your Long-Term Disability (LTD) Benefits

N/A

COST

Medical, Dental and Vision

You and Discover share the cost of medical and dental coverage. You pay the cost of vision coverage. For medical coverage, your share of the cost is determined by the coverage level you elect, your employment classification and your HWEE (see “Health and Welfare Eligible Earnings” section). Your share of the cost is automatically paid through pre-tax payroll deductions except for coverage for a domestic partner and his or her dependent children who do not qualify as your dependents under federal tax law. If your domestic partner and his or her eligible dependents are not your dependents under federal tax law, the full cost of medical, dental and vision coverage for your domestic partner (and his or her eligible dependents) is taxable to you and, therefore, added to your taxable income and reported on your Form W-2 as imputed income.

If your domestic partner and his or her dependents qualify as your dependents under federal and/or state tax law, you must return a Domestic Partnership Registration Form to myHR indicating their tax dependent status to avoid imputed income. Registration forms are available from myHR.

If you elect not to have medical, dental and/or vision coverage, you will be paid your compensation in cash each pay period over the plan year, subject to applicable federal, state and local income taxes and other withholdings.

Critical Illness Insurance

Discover pays the cost of basic critical illness coverage of \$3,000 for all individuals covered in the HRA and HSA plans. You pay the full cost of any additional voluntary coverage of \$20,000 through post-tax payroll deductions.

Life and Accident Insurance

Discover pays the full cost of your basic life insurance,* basic Accidental Death and Dismemberment (AD&D) insurance and Business Travel Accident (BTA) insurance coverage. You pay the full cost of supplemental life insurance coverage for yourself and your eligible dependents through after-tax contributions. Your cost for supplemental life insurance coverage for yourself depends upon your attained age at the beginning of the year and your elected coverage level. The cost of life insurance for your spouse/domestic partner depends on his or her age at the beginning of the year. The cost of supplemental life and AD&D insurance coverage for your eligible dependent children remains constant, regardless of your age or the number of dependent children you cover. Your cost for supplemental AD&D insurance will depend upon the coverage level and amount of coverage elected (your “principal sum”).

Disability

Discover pays the cost of providing your Short-Term Disability (STD) coverage. However, if you work in California, Hawaii, New Jersey, New York, Rhode Island or Puerto Rico, you will have a payroll deduction for your state-mandated STD program.

You pay the full cost of Long-Term Disability (LTD) coverage with after-tax payroll contributions. This way, any LTD benefit is generally free from federal income tax. LTD contribution rates are based on composite pricing (a blended rate for all LTD participants). As a result, your LTD rates may not reflect the actual cost of your particular risk profile based on your age.

Legal Assistance Program

You pay the full cost of the legal assistance program coverage through after-tax payroll deductions.

*Under IRS rules, the value of your basic life insurance over \$50,000 is considered taxable income to you. This taxable income will be reflected on your paycheck and W-2 Form as imputed income.

Flexible Spending Accounts

You pay the full cost of funding the Health Care Flexible Spending Account and/or the Dependent Day Care Flexible Spending Account with pre-tax dollars. The HCFSa can be used to reimburse you for eligible medical, prescription drug, dental and vision expenses and the DDCFSa can be used to reimburse you for eligible dependent care expenses.

In the event of a retroactive effective date, deductions begin with prospective pre-tax dollars even if coverage is retroactive to the date of eligibility or qualified life event date.

Paying for Benefits if You Are on Unpaid Leave or Participate in COBRA

If you go on an unpaid leave, or lose coverage for yourself or your dependent(s) and elect COBRA, you will be billed for your benefits coverage directly by myHR.

If you do not pay for coverage in a timely manner, coverage will be cancelled.

Note: During an unpaid personal leave you, will be billed 100% of the cost of your coverage. This means you are responsible for paying both your share of the cost and the Discoverer share of the cost of coverage.

Tobacco Surcharge

Tobacco users will pay a higher employee rate for medical and supplemental life insurance coverage to account for the increased cost of medical care and the lower life expectancy caused by tobacco use. You may avoid the tobacco surcharge by participating in a smoking cessation program such as QuitPower, which is available to you at no cost. Once a smoking cessation program is completed, the tobacco surcharge will be removed for the plan year. Removal of the tobacco surcharge is available to all employees. If you think you may be unable to complete the smoking cessation program, you may qualify for an opportunity to have the surcharge removed by different means. Contact myHR and we will work with you (and, if you wish, with your doctor) to find a smoking cessation program that is right for you in light of your health status.

Wellness Credit

You are eligible to receive up to a \$500 wellness credit if you are benefits eligible and complete both parts of the annual health evaluation, including the online health history and biometric screening by the administrative cut-off date designated as the end of the annual health evaluation period, generally sometime in November. You will receive a credit of \$300 for completing the evaluation, \$100 for allowing Interactive Health to send your results to your physician, and another \$100 if your spouse/ domestic partner completes the evaluation. The total wellness credit earned will be prorated over 26 pay periods and reduces the cost of your medical plan payroll contribution for the following plan year. The health evaluation is currently available through Interactive Health. If you are not enrolled in a Discover medical plan, you will not receive the credit, but you can still complete the health evaluation and access your results. In addition, you will receive a confidential report identifying your health risks and suggestions for improvement that you can share with your physician. You will receive more information on the health evaluation annually before annual enrollment.

HEALTH AND WELFARE ELIGIBLE EARNINGS (HWEE)

Throughout this SPD, there are references to HWEE. HWEE is used to determine the following:

- Your medical program contribution
- Your LTD contributions and benefit amounts
- Your basic and supplemental life insurance coverage amounts
- Your business travel accident (BTA) coverage amount

HWEE is generally the greater of

1. annualized base salary in effect at the time HWEE is calculated or
2. the most recent 12 months of eligible pay.

HWEE is calculated each September for use the following year.

Eligible Pay

Eligible pay is actual earnings, including pretax contributions to the company's 401(k) Plan and flex and commuter assistance plans, and paid equity awards. Eligible pay contributions do not include amounts payable as referral fees, expense allowances and imputed income.

If you are a current employee with at least 12 months of continuous service at Discover, your HWEE is generally the greater of your annualized base salary or your most recent 12 months of eligible earnings.

If you are a new hire (or have been rehired more than one year after you terminate employment with Discover), HWEE is generally your annualized base salary as of your hire date.

If you are rehired within 31 days following your date of termination of employment with Discover, your HWEE is generally your HWEE in effect at termination date. If you are rehired more than 31 days but less than one year following your date of termination, your HWEE is the greater of

1. your annualized base salary as of your rehire date or
2. your HWEE in effect at your termination date.

If you are a newly U.S. benefits-eligible employee because you transferred from an international non-U.S. benefits-eligible position, your HWEE is generally your annualized base salary at the time that HWEE is calculated.

When Coverage Ends

Your coverage as a participant in the plan will end on the earlier of:

- The last day of the month in which you are no longer an employee, for any reason
- The first day of the period for which required contributions have not been made
- The first day after you elect to no longer participate in a participating program
- The date of your death
- The date the plan is amended to consider you ineligible to participate
- The date the plan is terminated

An eligible dependent will no longer be a participant in the plan on the earlier of:

- The last day of the month in which the employee is no longer an eligible employee
- The last day of the month in which the dependent no longer meets the definition of an eligible dependent
- The date of the eligible employee's death¹

¹ A dependent may be eligible for continuation of existing medical, dental and vision coverage after an active employee's death. See the section "Continuation of Coverage During Work or Life Events" for information on dependent continuation of coverage upon an active employee's death.

- For a dependent who is a fully handicapped child, the date as described in the section “Definition of Fully Handicapped”
- The date a participant fails to provide the necessary information to determine an individual’s status as an eligible dependent, within the specified timeframe
- The date the plan is amended to consider the dependent ineligible to participate
- The date the plan is terminated

A participant (you or your dependents) may have rights to COBRA continuation coverage. See the section “Continuation Coverage Rights Under COBRA” for eligibility and information.

Certain participants may be eligible for retiree medical coverage. For complete information on eligibility and enrollment refer to the Retiree Welfare Benefits Plan Summary Plan Description, available on the myHR website.

Note: Certain coverage may end on a different date as described in the applicable plan section. In the event of a conflict between this section and the specific plan section, the specific plan section and terms will apply.

MEDICAL PROGRAM

The Discover medical program is designed to help you and your family manage the financial impact of both expected and unexpected medical expenses:

- The medical program is comprised of several medical program options as described within this SPD.
- The options available to you will vary by home state.
- Each option provides benefits for a broad range of medical services and supplies, in and out of the hospital, for illness, injury or pregnancy and includes prescription drug coverage.
- When you are no longer eligible to participate in the medical program, you and your eligible dependents may have an opportunity to continue coverage (at your own expense) under COBRA for a period of time. See the “Your Rights—COBRA” section for details.

Your Medical Program Options

The Discover medical program offers a variety of coverage and network options, allowing you to choose the coverage that best meets your family’s needs.

If you live in the U.S. (except Hawaii) and are benefits-eligible, you may choose from the following national medical program options, which offer both in- and out-of-network coverage:

- Blue Cross Blue Shield (BCBS) PPO
- Blue Cross Blue Shield (BCBS) HRA
- Blue Cross Blue Shield (BCBS) HSA

Based on your home or work location, you may be eligible for one or more of the following regional program options. Each of the following options offers “in-network” coverage only:

- HMSA Medical Plan—Hawaii, based on home zip code
- SelectHealth HMO and HSA —Utah, based on home zip code
- Kaiser HMO—Southern California, based on home zip code

CVS Caremark is the managed prescription drug vendor for the Blue Cross Blue Shield medical program options. For all other options, prescription drug coverage is provided under the applicable regional medical option. See the “Prescription Drug” section for details.

Listings of in-network providers are available without charge from the applicable medical program administrator or can be obtained on the myHR website (click on Health and Welfare, Planning Tools and Find a Health Care Provider). See the “Important Benefits Provider Contacts” section for all contact information.

If enrolled in the HSA Plan, ConnectYourCare is the administrator of the health savings account. HSA Bank is the actual bank where your HSA funds are deposited and can be invested. You can go through ConnectYourCare to access your HSA funds and link to HSA Bank to invest your HSA funds. Participants are eligible to make contributions to a health savings account if they are:

- Enrolled in the HSA plan
- Not covered in another health plan that is not a high deductible health plan
- Not enrolled in Medicare
- Not claimed as a dependent on another person’s tax return

Contributions to the health savings account can be made through pre-tax payroll deduction, or by making contributions directly to ConnectYourCare, up to the applicable annual limits. Changes to contributions can be made at any time by contacting myHR.

The health savings account is owned by you. Discover expects that you follow the applicable administrative requirements to ensure your account is set up. An open/active account is required in order for applicable payroll contributions and/or employer contributions to be deposited. If you fail to open your account, you may forfeit these contributions. Additional information on the health savings account is available in the “How the HSA Works” section, on **www.mydiscoverbenefits.com** and on the myHR website.

National Medical Program Options

National medical program options allow you to visit any independent doctor and receive medical care at any hospital that you or your doctor chooses.

However, your share of costs is lower when you visit an “in-network” provider. When you visit an in-network provider, you generally pay a fixed copay or an annual deductible before you pay 15% coinsurance for services. Copays do not count toward the deductible. Preventive services are often covered at 100%. You do not need to name a Primary Care Physician (PCP) or get a referral to see a specialist.

When you receive inpatient covered services from a non-participating provider or in an administrator program of a non-participating provider, benefits will be provided at 60% of the eligible charge, after you have met your program deductible. If you are in a private room, benefits will be limited by the hospital’s rate for its most common type of room with two or more beds.

For out-of-network services, you must satisfy an annual deductible before you are reimbursed 60% of the eligible charge, up to an annual coinsurance limit. Amounts in excess of the eligible charge do not count toward your annual deductible or coinsurance limit.

In the PPO and HRA plans, medical deductibles and copays apply to the annual out-of-pocket maximum. Prescription drug copays do not apply to the annual out-of-pocket maximum. If you reach the annual of pocket maximum, the plan pays 100% of eligible expenses for the rest of the year, except prescription drug expenses.

In the HSA Plan, if you cover dependents, you must meet the full family deductible before coinsurance applies. You must also meet the full family out-of-pocket maximum before Discover pays 100% of eligible expenses (medical and prescription drug) for the rest of the year.

Refer to the Schedule of Benefits on the following pages for a list of your cost share toward in- and out-of-network coverage, including a list of covered services and exclusions for each of the national medical program options.

Travel and Living Outside the U.S.

Note that Blue Cross Blue Shield pays benefits for covered persons while outside the United States. Eligible expenses for non-emergency Services incurred while outside the United States are reimbursed at the in-network benefit level and are subject to the deductible. Emergency services received outside the United States will be paid at the in-network benefit level subject to the deductible. If you receive treatment while traveling outside the United States, in most cases, you will have to pay for the services up-front and then submit an international claim form along with the receipt and an itemized bill from the provider.

You are encouraged to obtain medical documents and records before returning to the U.S. in order to be able to substantiate covered medical expenses if there is a need to review the medical necessity of the treatment. In order to ensure the highest level of reimbursement, you are encouraged to obtain all routine medical treatment in the U.S. before going abroad.

The BlueCard Worldwide program provided by Blue Cross Blue Shield offers access to worldwide network providers. In some cases, for inpatient treatment, arrangements can be made for cashless access to a hospital. For information on the BlueCard Worldwide program, contact the BlueCard Worldwide Service Center at **800-810-2583** or collect at **804-673-1177**. You can also search for providers on the **bcbasil.com** website.

Pre-Notification Requirements

Pre-notification to your health plan administrator is required for all inpatient admissions and certain other services. The medical program's medical management (or "care coordination") team will monitor your admission and treatment for quality, length of time and setting. You, someone acting on your behalf or your physician must contact your health plan administrator's member services department at the phone number shown on your ID card at least 48 hours before a scheduled inpatient admission or within 48 hours following an emergency admission.

Pre-notification is required for the following services:

- All inpatient admissions (at least 48 hours prior to scheduled admission or within 48 hours following an emergency admission)
- Maternity admission (if stay is longer than 48 hours for regular delivery or 96 hours for cesarean section)
- Hospital stays for newborns (if stay is longer than 48 hours for infants born through regular delivery or 96 hours for infants born through cesarean section)
- Reconstructive procedures
- Home health care (including home-infusion therapy)
- Organ and tissue transplants
- Hospice
- Skilled nursing
- Surgery for the diagnosis of morbid obesity

There will be a penalty charge of up to \$1,000 if you do not notify your health plan administrator within the prescribed time periods. The penalty amount applies to total expenses and is not applied to the deductible or annual coinsurance limit.

Pre-Authorization Requirements

Pre-authorization of your health plan administrator or pharmacy benefit manager is required for certain services to ensure they are medically necessary and based upon evidence-based medical guidelines.

Pre-authorization of your health plan administrator is required for the following services (see the “Prescription Drug Coverage” section for your pharmacy benefit manager’s pre-authorization requirements):

- Accidental dental
- Home health care services
- Hospice
- Reconstructive procedures
- Hospital inpatient stay
- Skilled nursing/inpatient
- Rehab facilities
- Maternity (inpatient stays greater than 48/96 hours)
- Transplant services
- Mental health/substance abuse
- Congenital heart disease resource services, if inpatient hospital stay is required
- Cochlear implant
- Hospice (including bereavement counseling)
- Organ and tissue transplant
- Skilled nursing facility
- Advanced radiological imaging (MRI, MRA, CAT scan, PET scan)

Failure to receive pre-authorization for any service requiring pre-authorization will result in the service not being covered, whether or not the service is determined to be medically necessary. Any amount you pay for services that are not pre-authorized, but are required to be, will not be applied to any deductible or annual coinsurance limit.

COORDINATION OF BENEFITS

The medical program contains a “non-duplication of benefits” provision, which ensures that the plan, in combination with any other plans, will never pay more than the amount the plan would pay on its own.

For example, if you cover your spouse as a dependent and your spouse is covered by another plan that pays benefits equal to or greater than the plan, the plan will generally make no additional payment. If another plan pays benefits that are less than the amount the plan would pay, the plan will pay up to the extent that total payments from both plans do not exceed what the plan would have paid for that claim.

The following coordination of benefits rules apply when a patient is covered by more than one plan:

- The plan covering the patient as an employee is considered “primary” and pays benefits up to plan limits. The plan covering the patient as a dependent is considered “secondary” and pays only to the extent that charges are eligible for reimbursement under the second plan. That means that your bills would first be submitted to the plan covering the patient as an employee, and any unpaid balances would then be submitted to the plan covering the patient as a dependent.
- The plan covering the parent whose birthday occurs earlier in the year (month and day) is primary and pays the children’s benefits first. The other parent’s group insurance is secondary and pays any remaining costs to the extent of coverage.
- The plan providing coverage to the active employee (or dependent of an active employee) is primary and will pay benefits before the plan that covers the individual as a retired employee (or dependent of a retired employee).

For dependents of divorced or legally separated parents:

- If there is a court order that makes one parent financially responsible for the health care expenses of the child, the plan of that parent will be primary to the plan of the other parent.
- If there is no such court order and the parent with custody of the child has not remarried, the plan of such parent will be primary to the plan of the parent without custody.
- If there is no such court order and the parent with custody of the child has remarried, the plan of the custodial parent will be primary to the plan of the step-parent. The plan of the step-parent will be primary to the parent without custody.

These rules assume the person covered by both plans is enrolled as an eligible dependent under the other person’s plan.

Schedule of Benefits—Blue Cross Blue Shield Options

The following is a general summary of the services covered and excluded under the Blue Cross Blue Shield (BCBS) options. The covered services and exclusions are subject to current medical guidelines and are covered at the discretion of the health plan administrator. Additional information on Blue Cross Blue Shield options is available on www.mydiscoverbenefits.com and the myHR website, or contact Blue Cross Blue Shield directly.

Important Notes

The following applies to all Blue Cross Blue Shield medical program Schedule of Benefits tables. See additional notes above the specific tables.

In-Network Services

- In-network services are services rendered by network providers and facilities, that is, by providers and facilities that participate in the medical program’s network.

Out-of-Network Services

- Out-of-network services are rendered by out-of-network providers or facilities, that is, by providers and facilities that do not participate in the medical program’s network.
- Out-of-network services are subject to balance billing over the allowed amount.
- The member is responsible for any deductible, coinsurance and amount above the eligible charges allowed amount. This also applies to any claim that received the in-network reimbursement level for a non-participating provider, for example durable medical equipment.

SCHEDULE OF BENEFITS: PROFESSIONAL SERVICES		
BLUE CROSS BLUE SHIELD NATIONAL MEDICAL PLANS		
	IN NETWORK¹	OUT OF NETWORK¹
DEDUCTIBLE AND MAXIMUMS		
ANNUAL DEDUCTIBLE (INDIVIDUAL/FAMILY)		
PPO	\$500/\$1,000	\$1,000/\$2,000
HRA	\$1,500/\$3,000	\$3,000/\$6,000
HSA	\$1,500/\$3,000 (must meet family deductible if you cover dependents)	\$3,000/\$6,000 (must meet family deductible if you cover dependents)
ANNUAL OUT-OF-POCKET MAXIMUM (INDIVIDUAL/FAMILY)²		
NOTE: NO LIFETIME MAXIMUM EXCEPT FOR INFERTILITY SERVICES		
PPO	\$2,000/\$4,000	\$4,000/\$8,000
HRA	\$3,000/\$6,000	\$6,000/\$12,000
HSA	\$3,000/\$6,000 (must meet family out-of-pocket maximum if you cover dependents)	\$6,000/\$12,000 (must meet family out-of-pocket maximum if you cover dependents)
OFFICE VISITS		
PREVENTIVE CARE		
PPO	100%	60% of eligible charges after deductible
HRA	100%	60% of eligible charges after deductible
HSA	100%	60% of eligible charges after deductible
PCP/NON-SPECIALIST (I.E., INTERNIST, FAMILY DOCTOR, PEDIATRICIAN)		
PPO	Office visit: 100% after \$30 copay All other services: 85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
SPECIALIST		
PPO	Office visit: 100% after \$40 copay All other services: 85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
ALLERGY TESTING AND TREATMENT		
PROFESSIONAL SERVICES IN NETWORK 100% FOR TESTING AND INJECTIONS; IF BILLED WITH OFFICE VISIT, COPAY WILL APPLY		
PPO	100% for testing and injections; if billed with office visit, \$30 copay will apply	60% of eligible charges after deductible
HRA	100% for testing and injections	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible

Continued on next page.

¹ See Important Notes at the beginning of this section.

² A separate out-of-pocket maximum applies for prescription drugs under the PPO and HRA plans. For the HSA plan, the out-of-pocket maximum for prescription drugs is integrated with the medical plan out-of-pocket maximum.

SCHEDULE OF BENEFITS: PROFESSIONAL SERVICES BLUE CROSS BLUE SHIELD NATIONAL MEDICAL PLANS		
	IN NETWORK¹	OUT OF NETWORK¹
ALL OTHER ALLERGY SERVICES		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
ANESTHESIA		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
COCHLEAR IMPLANT		
BI-LATERAL SENSORY-NEURAL HEARING LOSS AND SEVERELY DIFFICULT SPEECH DISCRIMINATION		
POST-LINGUAL SENSORY-NEURAL DEAFNESS IN AN ADULT		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
DENTAL		
ELIGIBLE SERVICES INCLUDE ONLY THOSE REQUIRED FOR SOUND NATURAL TEETH IF RENDERED WITHIN 6 MONTHS OF AN ACCIDENTAL INJURY OR CONGENITAL ANOMALY		
PPO	85% after deductible	60% of eligible charges after deductible Accidental injury services covered at the in-network benefit
HRA	85% after deductible	60% of eligible charges after deductible Accidental injury services covered at the in-network benefit
HSA	85% after deductible	60% of eligible charges after deductible
INFERTILITY (INCLUDES ARTIFICIAL INSEMINATION, IVF, GIFT, ZIFT)		
SUBJECT TO \$12,000 LIFETIME MEDICAL SERVICES MAXIMUM (COMBINED IN AND OUT-OF-NETWORK AND BETWEEN MEDICAL PLAN VENDORS)		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
SUBJECT TO \$10,000 LIFETIME PRESCRIPTION DRUG BENEFIT MAXIMUM		
PPO	See the "Prescription Drug Coverage" section	
HRA	See the "Prescription Drug Coverage" section	
HSA	See the "Prescription Drug Coverage" section	

Continued on next page.

¹ See Important Notes at the beginning of this section.

SCHEDULE OF BENEFITS: PROFESSIONAL SERVICES		
BLUE CROSS BLUE SHIELD NATIONAL MEDICAL PLANS		
	IN NETWORK¹	OUT OF NETWORK¹
RADIOLOGIST, ANESTHESIOLOGIST, PATHOLOGIST, LABORATORY		
SERVICES RENDERED IN AN IN-NETWORK FACILITY (INPATIENT HOSPITAL, OUTPATIENT HOSPITAL, AMBULATORY SURGICAL CENTER)		
PPO	85% after deductible	60% after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% after deductible
SERVICES RENDERED IN AN OUTPATIENT FACILITY		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
SURGERY		
SURGEON		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
ASSISTANT SURGEON—PAID BASED ON IN-NETWORK/OUT-OF-NETWORK STATUS OF FACILITY		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
SURGERY FOR MORBID OBESITY²		
PRE-AUTHORIZATION REQUIRED		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
SECOND SURGICAL OPINION		
PPO	Office visit: 100% after \$30 PCP/ \$40 specialist copay. All other services: 85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
MULTIPLE SURGICAL PROCEDURES ON SAME DAY		
PPO	Plan coverage levels vary for subsequent procedures when more than one surgical procedure is performed on the same day. Contact your health plan for details.	
HRA	Plan coverage levels vary for subsequent procedures when more than one surgical procedure is performed on the same day. Contact your health plan for details.	

Continued on next page.

¹ See Important Notes at the beginning of this section.

² For a member to be considered eligible for benefit coverage for bariatric surgery to treat morbid obesity, the member must meet two criteria:

¹⁾ diagnosis of morbid obesity, and

²⁾ required documentation from the requesting surgical program. For further information, see Exclusions section.

SCHEDULE OF BENEFITS: PROFESSIONAL SERVICES		
BLUE CROSS BLUE SHIELD NATIONAL MEDICAL PLANS		
	IN NETWORK ¹	OUT OF NETWORK ¹
HSA	Plan coverage levels vary for subsequent procedures when more than one surgical procedure is performed on the same day. Contact your health plan for details.	
VOLUNTARY STERILIZATION (REVERSALS ARE NOT COVERED)		
PPO	100% after \$30 PCP/\$40 specialist copay All other services: 85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
ABORTION		
PPO	Office visit: 100% after \$30 PCP/ \$40 specialist copay All other services: 85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
BIRTHING CENTER		
PPO	85% in hospital setting after deductible	60% of eligible charges after deductible
HRA	85% in hospital setting after deductible	60% of eligible charges after deductible
HSA	85% in hospital setting after deductible	60% of eligible charges after deductible

SCHEDULE OF BENEFITS: INPATIENT CARE BLUE CROSS BLUE SHIELD NATIONAL MEDICAL PLANS		
Note: You must notify a health plan administrator at least 48 hours prior to a scheduled admission or within 48 hours following an emergency hospital admission.		
	IN NETWORK¹	OUT OF NETWORK¹
HOSPICE (INCLUDING BEREAVEMENT COUNSELING)		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
HOSPITAL FACILITY CHARGE		
ACCIDENTAL INJURY		
MATERNITY/WELL NEWBORN		
MEDICAL REHABILITATION		
SEMI-PRIVATE ROOM ACCOMMODATION (PRIVATE ROOM PAID AT SEMI-PRIVATE ROOM RATE)		
PRE-NOTIFICATION REQUIRED		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible

Continued on next page.

¹ See Important Notes at the beginning of this section.

SCHEDULE OF BENEFITS: INPATIENT CARE BLUE CROSS BLUE SHIELD NATIONAL MEDICAL PLANS Note: You must notify a health plan administrator at least 48 hours prior to a scheduled admission or within 48 hours following an emergency hospital admission.		
	IN NETWORK ¹	OUT OF NETWORK ¹
HOSPITAL SERVICES		
INPATIENT SURGERY		
PRE-NOTIFICATION REQUIRED		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
ORGAN AND TISSUE TRANSPLANT		
HOSPITAL INPATIENT SERVICES AND ANCILLARIES		
SEMI-PRIVATE ROOM ACCOMMODATIONS (PRIVATE ROOM PAID AT SEMI-PRIVATE ROOM RATE)		
TRAVEL, MEALS AND LODGING (SEE THE TRANSPLANT TRAVEL AND LODGING GUIDELINES SECTION)		
PPO	85% after deductible	60% of eligible charges after deductible Covered at a designated transplant facility only
HRA	85% after deductible	60% of eligible charges after deductible Covered at a designated transplant facility only
HSA	85% after deductible	60% of eligible charges after deductible Covered at a designated transplant facility only
SKILLED NURSING FACILITY		
120-DAY ANNUAL LIMIT (COMBINED IN-NETWORK AND OUT-OF-NETWORK)		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible

SCHEDULE OF BENEFITS: EMERGENCY CARE BLUE CROSS BLUE SHIELD NATIONAL MEDICAL PLANS Note: You must notify a health plan administrator at least 48 hours prior to scheduled admission or within 48 hours following an emergency hospital admission.		
	IN NETWORK ¹	OUT OF NETWORK ¹
AIR AND GROUND AMBULANCE SERVICE		
PPO	85% after deductible	85% of eligible charges after deductible
HRA	85% after deductible	85% of eligible charges after deductible
HSA	85% after deductible	85% of eligible charges after deductible
HOSPITAL EMERGENCY ROOM		
FACILITY CHARGES (COPAY WAIVED IF ADMITTED)		
PPO	100% after \$250 copay	100% after \$250 copay
HRA	100% after \$250 copay	100% after \$250 copay
HSA	85% after deductible	85% of eligible charges after deductible
OTHER CHARGES, ER PHYSICIAN OR ANY OTHER CHARGES BILLED SEPARATELY FROM FACILITY CHARGE PAID AT COINSURANCE		
PPO	85% after deductible	85% of eligible charges after deductible
HRA	85% after deductible	85% of eligible charges after deductible
HSA	85% after deductible	85% of eligible charges after deductible
URGENT CARE CENTER		
FACILITY CHARGES		
PPO	100% after \$35 copay	60% of eligible charges after deductible, if non-emergency Same as in-network if emergency
HRA	100% after \$35 copay	60% of eligible charges after deductible, if non-emergency Same as in-network if emergency
HSA	85% after deductible	60% of eligible charges after deductible, if non-emergency Same as in-network if emergency
OTHER CHARGES		
PPO	85% after deductible	60% of eligible charges after deductible, if non-emergency Same as in-network if emergency
HRA	85% after deductible	60% of eligible charges after deductible, if non-emergency Same as in-network if emergency
HSA	85% after deductible	60% of eligible charges after deductible, if non-emergency Same as in-network if emergency

¹ See Important Notes at the beginning of this section.

SCHEDULE OF BENEFITS: OUTPATIENT CARE		
BLUE CROSS BLUE SHIELD NATIONAL MEDICAL PLANS		
Notes: 1. All annual visit limitations are combined in-network and out-of-network services, and 2. All pre-notification requirements apply to both in-network and out-of-network services.		
	IN NETWORK¹	OUT OF NETWORK¹
ACUPUNCTURE		
20 VISITS PER CALENDAR YEAR		
MUST BE PERFORMED BY AN MD OR A CERTIFIED ACUPUNCTURIST		
PPO	100% after \$30 PCP/\$40 specialist copay per visit	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
CHEMOTHERAPY, RADIATION AND BLOOD THERAPY		
PPO	85% after deductible All other settings 100% after the \$30 PCP/\$40 specialist copay	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
CHIROPRACTIC CARE		
30 VISITS PER CALENDAR YEAR		
PPO	100% after \$30 copay per visit	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
DIAGNOSTIC X-RAYS, LAB TESTS AND PROCEDURES (NON-PREVENTIVE)		
ADVANCED RADIOLOGICAL IMAGING (MRI, MRA, CAT SCAN, PET SCAN)		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
ALL OTHER		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
NUTRITIONAL COUNSELING		
COVERED BENEFIT WHEN RENDERED BY A REGISTERED DIETICIAN FOR CHRONIC DISEASES OR CONDITIONS IN WHICH A DIETARY ADJUSTMENT HAS A THERAPEUTIC ROLE. MUST BE DUE TO AND UNDER THE DIRECT SUPERVISION OF AN MD OR CERTIFIED LICENSED DIETICIAN.		
PPO	100%	60% of eligible charges after deductible
HRA	100%	60% of eligible charges after deductible
HSA	100%	60% of eligible charges after deductible

Continued on next page.

¹ See Important Notes at the beginning of this section.

SCHEDULE OF BENEFITS: OUTPATIENT CARE		
BLUE CROSS BLUE SHIELD NATIONAL MEDICAL PLANS		
Notes: 1. All annual visit limitations are combined in-network and out-of-network services, and 2. All pre-notification requirements apply to both in-network and out-of-network services.		
	IN NETWORK¹	OUT OF NETWORK¹
OCCUPATIONAL THERAPY		
30 VISITS PER CALENDAR YEAR		
ADDITIONAL VISITS MAY BE AVAILABLE WITH PRE-AUTHORIZATION		
PPO	100% after \$30 copay per visit	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
PHYSICAL THERAPY		
30 VISITS PER CALENDAR YEAR		
ADDITIONAL VISITS MAY BE AVAILABLE WITH PRE-AUTHORIZATION		
PPO	100% after \$30 copay per visit	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
PRE-SURGICAL TESTING		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
RESPIRATORY AND CARDIAC THERAPY		
PPO	100% after \$30 copay per visit	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
SPEECH AND HEARING THERAPY (COMBINED)		
30-VISIT ANNUAL LIMIT		
ADDITIONAL VISITS MAY BE AVAILABLE WITH PRE-AUTHORIZATION		
DEVELOPMENTAL DELAYS ARE COVERED UP TO AGE 18		
PPO	100% after \$30 copay per visit	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
SURGERY, AMBULATORY SURGERY, CLINIC AND OTHER OUTPATIENT SERVICES		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible

Continued on next page.

¹ See Important Notes at the beginning of this section.

SCHEDULE OF BENEFITS: OUTPATIENT CARE

BLUE CROSS BLUE SHIELD NATIONAL MEDICAL PLANS

Notes: 1. All annual visit limitations are combined in-network and out-of-network services, and
2. All pre-notification requirements apply to both in-network and out-of-network services.

	IN NETWORK ¹	OUT OF NETWORK ¹
VISION THERAPY		
30-VISIT ANNUAL LIMIT		
ADDITIONAL VISITS MAY BE AVAILABLE WITH PRE-AUTHORIZATION		
PPO	100% after \$30 copay per visit	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible

SCHEDULE OF BENEFITS: MENTAL HEALTH AND SUBSTANCE USE DISORDER

BLUE CROSS BLUE SHIELD NATIONAL MEDICAL PLANS

Notes: 1) Mental health and substance use disorders are covered the same as any other illness.
2) Pre-notification is required for all Inpatient services for both in-network and out-of-network services.
3) Pre-notification is required for Inpatient Residential Treatment. The facility must be a Licensed Residential Treatment Facility.

	IN NETWORK ¹	OUT OF NETWORK ¹
SUBSTANCE USE DISORDER		
OUTPATIENT		
PPO	100% after \$30 PCP/\$40 Specialist copay per visit	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
INPATIENT (PRE-NOTIFICATION REQUIRED)		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible

¹ See Important Notes at the beginning of this section.

SCHEDULE OF BENEFITS: WELLNESS CARE BLUE CROSS BLUE SHIELD NATIONAL MEDICAL PLANS		
	IN NETWORK^{1,2}	OUT OF NETWORK
WELLNESS CARE		
CHOLESTEROL SCREENING		
COLON CANCER SCREENING		
DIAGNOSTIC X-RAYS, SCANS AND LAB TESTS (PREVENTIVE)		
IMMUNIZATIONS (EXCLUDES TRAVEL IMMUNIZATIONS)		
MAMMOGRAPHY (PREVENTIVE)		
PAP SMEAR (ROUTINE)		
PROSTATE CANCER SCREENING (PSA)		
ROUTINE GYN EXAM		
PPO	100%	60% of eligible charges after deductible
HRA	100%	60% of eligible charges after deductible
HSA	100%	60% of eligible charges after deductible
ROUTINE PHYSICAL (INCLUDES THE FOLLOWING AMERICAN MEDICAL ASSOCIATION APPROVED DIAGNOSTIC SCREENING TESTS)		
STANDARD LAB TESTS, SUCH AS URINALYSIS, SMA, CBC, ETC.		
STANDARD X-RAYS, SUCH AS BI-LATERAL CHEST X-RAY		
FECAL OCCULT BLOOD TEST		
ROUTINE ELECTROCARDIOGRAM (WITH 12 LEADS)		
PPO	100%	60% of eligible charges after deductible
HRA	100%	60% of eligible charges after deductible
HSA	100%	60% of eligible charges after deductible
WELL BABY CARE		
ROUTINE IMMUNIZATIONS COVERED AT 100%		
PPO	100%	60% of eligible charges after deductible
HRA	100%	60% of eligible charges after deductible
HSA	100%	60% of eligible charges after deductible
ADDITIONAL PREVENTIVE CARE FOR WOMEN (BY LAW UNDER THE AFFORDABLE CARE ACT)		
DIABETES SCREENING		
BREASTFEEDING SUPPORT, SUPPLIES AND COUNSELING		
FDA-APPROVED CONTRACEPTIVE METHODS AND CONTRACEPTIVE EDUCATION		
HPV DNA TESTING FOR WOMEN, 30 OR OLDER		
SEXUALLY TRANSMITTED INFECTIONS COUNSELING		
HIV SCREENING AND COUNSELING		
DOMESTIC AND INTERPERSONAL VIOLENCE SCREENING AND COUNSELING		
PPO	100%	60% of eligible charges after deductible
HRA	100%	60% of eligible charges after deductible
HSA	100%	60% of eligible charges after deductible

¹ See Important Notes at the beginning of this section.

² If you have questions regarding preventive care, contact BCBS member services.

SCHEDULE OF BENEFITS: OTHER		
BLUE CROSS BLUE SHIELD NATIONAL MEDICAL PLANS		
	IN NETWORK¹	OUT OF NETWORK¹
BIRTH CONTROL		
IUDS, DEPO-PROVERA INJECTIONS, DIAPHRAGMS AND NORPLANT		
PPO	Office visit: 100% after \$30 PCP/\$40 specialist copay All other services: 85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	Office visit: 100% after \$30 PCP/\$40 specialist copay All other services: 85% after deductible	60% of eligible charges after deductible
GENDER REASSIGNMENT SURGERY²		
LIFETIME MAXIMUM OF \$75,000		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
HEARING AIDS		
\$1,500 MAXIMUM BENEFIT EVERY 36 MONTHS		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
HOME HEALTH CARE/PRIVATE DUTY NURSING		
200-VISIT ANNUAL LIMIT		
PRE-NOTIFICATION REQUIRED		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible

Continued on next page.

¹ See Important Notes at the beginning of this section.

² Gender reassignment surgery benefits will be provided for covered services rendered to persons age 18 and over.

Conditions for coverage apply:

- The individual is at least 18 years of age
- The individual has been diagnosed with the gender identity disorder (GID) of trans-sexualism
- The individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician
- The individual has completed a minimum of 12 months of successful continuous full time real-life experience in their new gender, with no returning to their original gender
- A letter from the individual's physician or mental health provider documenting treatments and medical necessity

See the "Exclusions" section for additional information.

SCHEDULE OF BENEFITS: OTHER		
BLUE CROSS BLUE SHIELD NATIONAL MEDICAL PLANS		
	IN NETWORK¹	OUT OF NETWORK¹
NEWBORN CIRCUMCISION		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible
PRESCRIBED DURABLE MEDICAL EQUIPMENT		
PPO	85% after deductible	60% of eligible charges after deductible
HRA	85% after deductible	60% of eligible charges after deductible
HSA	85% after deductible	60% of eligible charges after deductible

SCHEDULE OF BENEFITS TRANSPLANT AND CANCER	
TREATMENT TRAVEL AND LODGING	
BLUE CROSS BLUE SHIELD NATIONAL MEDICAL PLANS	
Notes: 1) Guidelines apply outside 50-mile radius of transplant facility. 2) Total benefit is limited to \$10,000 per lifetime (\$25,000 per lifetime for bone marrow BCBS only), including transplant donor's travel and lodging.	
TRANSPLANT COVERED ITEMS	
LODGING	Allowance of \$50 per day if transplant is covered (BCBS only)
	Hotel, motel or apartment rental
TRAVEL	100% covered, up to total lifetime maximum listed above
	Coach, air, train and airbus fares, car rental including mileage (if charged by car rental agency), gas, parking (excluding valet) and tolls
	Travel is reimbursed for patient and companion (two companions if the patient is a minor child)
TRANSPLANT NON-COVERED ITEMS	
CONVENIENCE AND ENTERTAINMENT	Telephone, fax
	Movies, books and video rentals
FOOD AND GROCERIES	Meals
	Alcoholic beverages, paper products, toiletries, personal hygiene products
MISCELLANEOUS	Laundry service or dry cleaning, laundry detergent
	Gratuities of any kind (excluding meals)
	Cooking utensils, appliances and furniture for apartment rentals
TRAVEL	Personal car mileage, first class and business class airfare, U-hauls

¹ See Important Notes at the beginning of this section.

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ACT OF WAR	Any loss caused or contributed to by war or any act of war, declared or undeclared, or by illness/injury sustained while in the armed forces of any country
CUSTODIAL/ CONVALESCENT CARE	Services for confinement for custodial or convalescent care, rest cures or long-term custodial hospital care. This is care made up of services and supplies that meet one of the following conditions: <ul style="list-style-type: none"> • Are non-health-related services such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating) • Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the services is not changing, or • not require continued administration by trained medical personnel in order to be delivered safely and effectively
DENTAL SERVICES	Any dental services, other than those required as a result of an accidental injury to sound natural teeth if service is provided within 6 months of injury or congenital anomalies
	Doctor's services for X-ray examinations in conjunction with mouth conditions due to a periodontal or periapical disease, or any condition (other than a malignant tumor) involving teeth, surrounding tissue or structure, the alveolar process or the gingival tissue to, periodontal treatment, endodontic services, extractions, implants or any treatment to improve the ability to chew or speak
	Surgical correction or other treatment of malocclusion
	Treatment of Temporomandibular Joint (TMJ) disorders and all other craniomandibular disorders (also see exclusions under "TMJ")
	Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following: <ul style="list-style-type: none"> • Extractions, restoration and replacement of teeth • Medical or surgical treatments of dental conditions • Services to improve dental clinical outcomes
	Dental implants, except for those associated with congenital anomalies
	Dental braces
	Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following: <ul style="list-style-type: none"> • Transplant preparation • Initiation of immunosuppressives • The direct treatment of acute traumatic injury, cancer or cleft palate

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ELIGIBILITY	Charges for treatment or supplies received (a) before coverage under this plan begins, or (b) after it is terminated, including health services for medical conditions arising before the date your coverage, under the plan, ends
	Expenses incurred by a dependent if the dependent is covered as an employee for the same services under this plan
EXPERIMENTAL/ INVESTIGATIVE	Treatments of any kind, which are considered by the plan administration to be experimental, investigative and educational, or are provided primarily for research. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be experimental or investigational or unproven in the treatment of the particular condition
	Cancer clinical trials
FOOT CARE	Routine foot care, including care of corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet and chronic foot strain, except to treat severe systemic disease (foot care related to diabetes and peripheral vascular disease is covered)
	Symptomatic complaints of the feet except capsular or bone surgery related to bunions and hammertoes
	Shoe orthotics except for custom-molded shoe inserts
	Hygienic and preventive maintenance foot care. Examples include the following:
	<ul style="list-style-type: none"> • Cleaning and soaking the feet • Applying skin creams in order to maintain skin tone • Other services that are performed when there is not a localized illness, injury or symptom involving the foot • Treatment of subluxation of the foot
GOVERNMENT AGENCY/LAWS/ PLANS	Services or supplies furnished by or reimbursable through a government-sponsored agency or program (except as provided under the Medicare secondary payer rules)
	Services for care provided in any government hospital or facility when the individual is eligible for government benefits
	Services or supplies (a) furnished by or for any government, unless payment is legally required, or (b) to the extent that such services or supplies are provided by any governmental program or law under which the individual is, or could be covered. Item (b) does not apply to Medicaid or to any law or plan when, by law, its benefits are in excess to a private plan or program
	Services for care provided under certain government laws
	Services covered under Worker's Compensation, no-fault automobile insurance or similar statutory programs

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GOVERNMENT AGENCY/LAWS/ PLANS	Services furnished by governmental plans
	Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you
	Health services while on active military duty
HOSPITAL CHARGES	Charges made by a hospital for confinement in a special area of the hospital, which provides non-acute care, by whatever name called, including but not limited to the type of care given by the facilities listed below. If that type of facility is otherwise covered under this plan, then benefits for that covered facility which is part of a hospital, as defined, are payable at the coverage level for that facility, not at the coverage level for a hospital. <ul style="list-style-type: none"> • Adult or child day care center • Ambulatory surgical center • Birth center (birth centers are standardly paid same as the hospital benefit) • Half-way house • Hospice • Skilled nursing facility • Treatment center • Vocational rehabilitation center
	Any other area of a hospital which renders services on an inpatient basis for other than acute care of sick, injured or pregnant persons
MEDICAL SUPPLIES AND APPLIANCES	Devices used specifically as safety items or to affect performance in sports-related activities
	Prescribed or non-prescribed supplies
	Orthotic appliances that straighten or reshape a body part (including some types or braces)
	Tubings, nasal cannulas, connectors and masks are not covered except when used with durable medical equipment
MEDICATIONS	Services for prescription and nonprescription medications unless provided by a hospital in conjunction with admission
	Prescription drug products for outpatient use that are filled by a prescription order or refill
	Self-injectable medications given in a physician's office except as required in an emergency
	Over-the-counter drugs and treatments

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MENTAL HEALTH/ SUBSTANCE ABUSE	Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
	Services for mental health/substance abuse that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention
	Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other mental illnesses that will not substantially improve beyond the current level or functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the mental health vendor
	Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methodol), Cyclazocine, or their equivalents
	Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the mental health/substance abuse vendor
	Services or supplies for the diagnosis or treatment of mental illness, alcoholism or substance abuse disorder that, in the reasonable judgment of the mental health/substance abuse vendor, are any of the following: <ul style="list-style-type: none"> • Not consistent with prevailing national standards of clinical practice for the treatment of such conditions • Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome • Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective • Not consistent with the mental health/substance abuse vendor's guidelines or best practices as modified from time to time <p>The mental health/substance abuse vendor may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.</p>
	Routine use of psychological testing without specific authorization
MISCELLANEOUS	Eyeglasses or contact lenses unless required due to accidental injury or cataract surgery
	Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as radial keratotomy, laser and other refractive eye surgery
	Lamaze classes
	Ecological or environmental medicine, diagnosis and/or treatment
	Herbal medicine, holistic or homeopathic care, including drugs

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MISCELLANEOUS	Acupressure, aromatherapy, hypnotism, rolfing and other forms of alternative medicine as defined by the Office of Alternative Medicine of the National Institutes of Health
	Chelation therapy, except to treat heavy metal poisoning
	Circumcision not performed in a hospital as part of initial hospital stay
	Naturopaths and naturalists
	Membership costs for health clubs, weight loss clinics and similar programs
	Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation
	Personal trainers
	Liposuction
	Massage therapy, unless part of chiropractic services
	Enteral feedings and other nutritional and electrolyte formulas, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins and oral minerals except when a certain enteral formula is needed for inborn errors of metabolism or when used directly to treat and control symptoms and progression of an illness or disease. Must also be sole source of nutrition. Formula is a covered eligible expense with a diagnosis of phenylketonuria (pre-approval required).
	Vitamins, minerals and megavitamin and nutrition-based therapy
	Travel or transportation expenses, even though prescribed by a physician, unless provided under the travel and lodging provision
	In the event that a non-network provider waives copayments and/or the deductible for a particular health service, no benefits are provided for the health service for which the copayments and/or deductible are waived
	Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke or a congenital anomaly, and except for developmental delay in children under 18
	Psychosurgery
	Treatment of benign gynecomastia (abnormal breast enlargement in males)
	Medical and surgical treatment of excessive sweating (hyperhidrosis)
	Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea
	Appliances for snoring
	Any charges for room or facility reservations or record processing

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MISCELLANEOUS	Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment
	Any charge for services, supplies or equipment advertised by the provider as free
	Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency
	Any charges prohibited by federal anti-kickback or self-referral statutes
	Any charges by a resident in a teaching hospital where a faculty physician did not supervise services
	Maintenance or preventative treatment consisting of routine, long-term or non-medically necessary care provided to prevent recurrences or to maintain the patient's current status
	Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness such as asthma or allergies
	Speech therapy to treat stuttering, stammering or other articulation disorders
	Services performed by Christian Science practitioners
	Surrogate reproduction or services
	Surrogate parenting
	The reversal of voluntary sterilization, fees or direct payment to a donor for sperm or ovum donations
	Monthly fees for maintenance and/or storage of frozen embryos
	Health services associated with the use of nonsurgical or drug-induced pregnancy termination
SMOKING CESSATION PROGRAMS	Transdermal patches/Nicorette gum
	Treatment provided in connection with tobacco dependency
SPECIAL CHARGES/ SERVICES	Any services, treatments or supplies that are not medically necessary for the prevention, diagnosis or treatment of an illness, injury or pregnancy.
	Health services and supplies that do not meet the definition of covered service, as defined in the Glossary section
	Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the plan when: <ul style="list-style-type: none"> • Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption • Related to judicial or administrative proceedings or orders • Conducted for purposes of medical research • Required to obtain or maintain a license of any type
	Services for hospital confinement primarily for diagnostic studies

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SPECIAL CHARGES/ SERVICES	Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home
	Services, supplies, medical care or treatment given by one of the following members of the employee's immediate family: <ul style="list-style-type: none"> • The employee's spouse/domestic partner, or • The child, brother, sister, parent or grandparent of either the employee or the employee's spouse/domestic partner
	Services performed by a provider with your same legal residence
	Charges to the extent in excess of the eligible charges, other than for out-of-network emergency room services or emergency transportation
	Fees or charges made by an individual, agency or facility operating beyond the scope of its license
	Services and supplies for which no charge is made or for which you or a dependent have no legal obligation
	Services given by volunteers or persons who do not normally charge for their services
	Services for telephone consultations, charges for failure to keep a scheduled visit, charges for completion of a claim form or charges for giving information concerning a claim
	Charges for any confinement or treatment given in connection with a service or supply that is not covered under the plan
	Separate charges by interns, residents, house physicians or other health care professionals who are employed by the covered facility
	Services provided at a freestanding or hospital-based diagnostic facility without an order written by a physician or other provider. Services that are self-directed to a freestanding or hospital-based diagnostic facility. Services ordered by a physician or other provider who is an employee or representative of a free-standing or hospital-based diagnostic facility, when that physician or other provider a) has not been actively involved in your medical care prior to ordering the service, or b) is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography testing
	Standby services required by a physician
	Services given by a pastoral counselor
	Expenses you would not be required to pay for if there were no health coverage
	Devices and computers to assist in communication and speech. Home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools)

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SPECIAL CHARGES/ SERVICES	<p>Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that are, at the time of determination:</p> <ul style="list-style-type: none"> • Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use • Subject to review and approval by any institutional review board for the proposed use, or the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight, or not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed
SURGERY	<p>Services for cosmetic procedures, which are defined as procedures or services that change or improve appearance without significantly improving physiological function, as determined by the claims administrator, except for reconstructive surgery following a mastectomy. Examples include:</p> <ul style="list-style-type: none"> • Pharmacological regimens, nutritional procedures or treatments • Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures) • Skin abrasion procedures performed as a treatment for acne <p>Reconstructive procedures are covered. Services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By improving or restoring physiologic function, it is meant that the target organ or body part is made to work better. Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry as mandated by the Women's Health and Cancer Rights Act of 1998.</p> <p>Benefits for gender reassignment surgery exclude transportation and lodging expenses, reversals, and surgeries that are considered to be cosmetic. The following surgeries are considered cosmetic and will not be covered for an individual who has undergone or is planning to undergo gender reassignment surgery: reduction thyroid, chondroplasty, liposuction, rhinoplasty, facial bone reconstruction, face lift, blepharoplasty, voice modification surgery, hair removal/hairplasty and breast augmentation.</p> <p>Reversal of vasectomy or tubal ligation</p> <p>Upper and lower jawbone surgery is not covered except as required for direct treatment of acute traumatic injury or cancer</p>

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SURGERY	Orthognathic surgery, jaw alignment and treatment of TMJ, except as treatment for obstructive sleep apnea or to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided that the deformity or disfigurement is accompanied by a documented clinically significant functional impairment and there is responsible expectation that the procedure will result in meaningful functional improvement; or the orthognathic surgery is medically necessary as a result of tumor, trauma, disease; or the orthognathic surgery is performed prior to age 19 and is required as a result of a severe congenital facial deformity or congenital condition. Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements and there is a high probability of significant additional improvement as determined by the utilization review.
TEMPOROMANDIBULAR JOINT (TMJ) DISORDER	Services for the evaluation and treatment of TemporoMandibular Joint syndrome (TMJ), when the services are considered to be medical or dental in nature, including oral appliances
	Treatment for all other craniomandibular disorders
TRANSPLANT SERVICES	Health services for transplants involving mechanical or animal organs
	Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person
	Health services for organ and tissue transplants which do meet the definition of a Covered Health Service or which are Experimental or Investigational, or Unproven. Examples of transplants for which benefits are available include, but are not limited to, the list below. Multiple organ transplants must be determined by Blue Cross Blue Shield to be appropriate according to Blue Cross Blue Shield's transplant guidelines: <ul style="list-style-type: none"> • Heart transplants • Heart/lung transplants • Lung transplants • Kidney transplants • Kidney/pancreas transplants • Liver transplants • Liver/small bowel transplants • Pancreas transplant • Small bowel transplants • Some bone marrow transplants
VISION CARE	Routine vision care
	Vision Perception Training
WEIGHT-RELATED	Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
	Nonsurgical treatment of obesity, including morbid obesity

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WEIGHT-RELATED

Surgical treatment of obesity. Unless morbid obesity as defined. To be considered eligible for benefit coverage for bariatric surgery to treat morbid obesity, the following two criteria must be met:

1. Diagnosis of morbid obesity, defined as a:

- Body mass index (BMI) equal to or greater than 40 kg/meter; OR
- BMI equal to or greater than 35kg/meter with at least two (2) of the following comorbid conditions related to obesity that have not responded to maximum medical management and that are generally expected to be reversed or improved by bariatric treatment:
 - Hypertension, OR
 - Dyslipidemia, OR
 - Diabetes mellitus, OR
 - Coronary heart disease, OR
 - Sleep apnea, OR
 - Osteoarthritis; AND

2. Documentation from the requesting surgical program that:

- Growth is completed (generally, growth is considered completed by 18 years of age); AND
- Documentation from the surgeon attesting that the patient has been educated in and understands the post-operative regimen, which should include ALL of the following components:
 - Nutrition program, which may include a very low calorie diet or a recognized commercial diet--based weight loss program; AND
 - Behavior modification or behavioral health interventions; AND
 - Counseling and instruction on exercise and increased physical activity; AND
 - Ongoing support for lifestyle changes to make and maintain appropriate choices that will reduce health risk factors and improve overall health; AND
- Patient has completed an evaluation by a licensed professional counselor, psychologist or psychiatrist within the 12 months preceding the request for surgery. This evaluation should document:
 - The absence of significant psychopathology that would hinder the ability of an individual to understand the procedure and comply with medical/surgical recommendations, AND

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WEIGHT-RELATED	<ul style="list-style-type: none"> — The absence of any psychological comorbidity that could contribute to weight mismanagement or a diagnosed eating disorder, AND — The patient's willingness to comply with preoperative and postoperative treatment plans. <p>Contraindications for surgical treatment of obesity include:</p> <ul style="list-style-type: none"> • Patients with mental handicaps that render a patient unable to understand the rules of eating and exercise and therefore make them unable to participate effectively in the post-operative treatment program (e.g., a patient with malignant hyperphagia [Prader-Willi syndrome], which combines mental retardation with an uncontrollable desire for food). • Patients with portal hypertension, an excessive hazard with laparoscopic gastric surgery. • Women who are pregnant or lactating. • Patients with serious medical illness in whom caloric restriction could exacerbate the illness. • Abdominoplasty, unless the following conditions are met: <ul style="list-style-type: none"> — Panniculus hangs to or below the level of the pubis; and causes chronic intertrigo that consistently reoccurs or remains refractory to appropriate medical therapy that includes systemic antibiotics, topical anti-infectives, anti-inflammatory medication and appropriate skin hygiene; OR — Repair of diastasis recti in the presence of a true midline hernia (ventral or umbilical). • Abdominoplasty is considered cosmetic when the procedure is performed to: <ul style="list-style-type: none"> — Remove excess skin and fat from the middle and lower abdomen in order to contour, alter, and improve the appearance of the abdominal area — Repair diastasis recti without the presence of a true midline hernia
WIGS/TOUPEES	<p>Wigs or toupees, unless the cause is cancer, alopecia, dermatophytosis of scalp, leukemia, lupus erythematosus, diseases that cause hair loss, burns or injuries that caused hair loss or prevent hair re-growth and drugs that cause hair loss including radiation or chemotherapy. For these purposes, there is a limit of one wig/toupee per person per calendar year. Coverage is 85% of eligible charges in- and out-of-network, up to \$500. Institutional services are covered at 85% of eligible charges in-network and 60% of eligible charges out-of-network, subject to a deductible</p> <p>Hair transplants, hair weaving or any drug if such drug is used in connection with baldness or to promote hair growth</p>
WORK-RELATED	<p>Services for occupational injury or illness which is covered under Workers' Compensation or similar laws</p> <p>Occupational injury or illness includes any injury or illness that would have been covered under Workers' Compensation act or similar law had available coverage been elected</p>

How the HSA Works

In early January, Discover makes the first of four quarterly contributions to your HSA. The amount Discover contributes depends on your coverage level:

YOU ONLY	YOU + SPOUSE/PARTNER	YOU + CHILD(REN)	YOU + FAMILY
\$400 (\$100 quarterly) ¹	\$700 (\$175 quarterly) ¹	\$700 (\$175 quarterly) ¹	\$1000 (\$250 quarterly) ¹

¹ The first contribution is made around January 1. The other contributions are made at the beginning of the calendar quarter, as soon as administratively possible

Important Things to Know About HSAs

- The HSA is a savings account that has FDIC protection.
- Your HSA will be set up automatically after you enroll in the HSA Plan. You must have an open account to receive HSA contributions from you and Discover.
- There's no "use it or lose it" rule for HSA money. However, if you set up a limited-purpose Health Care FSA with your HSA, "use it or lose it" will apply to your FSA dollars—that is, an FSA balance after the reimbursement deadline will be forfeited – unless your FSA balance is \$500 or less. You can pay for prescription drugs with HSA funds.
- You can invest your HSA balance, and any interest and investment earnings are free of federal taxes. Visit the ConnectYourCare website for details. Certain states may tax the earnings, however. Consult your tax adviser.
- If you cover dependents, you must meet the full family deductible before coinsurance applies. You must also meet the full family annual out-of-pocket maximum before Discover pays 100% of eligible expenses for the rest of the year.
- You can use the HSA for your spouse and children even if they are not covered under your plan for eligible health care expenses, but only if they are enrolled in another qualified high-deductible medical plan. If you are also enrolled in a limited-purpose Health Care FSA, you cannot use FSA money for your spouse's medical expenses. Current IRS regulations prohibit this practice.
- You can use your HSA for eligible expenses incurred by your domestic partner and his/her eligible children only if you claim them as your dependents on your federal income tax return. Otherwise, it is not allowed.
- Whether you are eligible for reimbursement of your covered adult children's eligible expenses will depend on whether the child qualifies as your dependent on your federal income tax return. Otherwise, the reimbursement will be taxable.
- Keep receipts for eligible expenses paid from your HSA. Without them, you may have to pay taxes and penalties.
- If you leave Discover and enroll in COBRA coverage, Discover's contribution to your HSA stops. However, your COBRA cost will be reduced to offset the value of the Discover contribution.
- You own your HSA. If you leave Discover, it goes with you. You can either leave it with ConnectYourCare and HSA Bank, or transfer your balance to another HSA administrator. It's your choice.
- If you are age 55 or older and not enrolled in Medicare, you can make additional "catch-up" contributions (up to \$1,000 in 2015, subject to annual adjustment) to help you save for eligible expenses before or during retirement.

- Before age 65, you'll pay income tax and a 20% penalty on HSA funds used for non-eligible expenses. From age 65 on, no penalties apply. Other exceptions include death and disability. See IRS Publication 969 on irs.gov for details and a complete list of eligible expenses.
- You are not eligible for an HSA after you have enrolled in Medicare. If you had an HSA before you enrolled in Medicare, you can keep it. However, you cannot continue to make contributions to an HSA after you enroll in Medicare.
- When you enroll in Medicare, you can use your account to pay Medicare premiums, deductibles, copays and coinsurance under any part of Medicare. You can also use HSA funds to pay for things other than medical expenses, but you'll pay income tax on those expenses.
- The HSA is not available to Discover retirees.
- Currently in Alabama, New Jersey and California, HSA contributions are subject to state income tax. Consult your tax advisor for information about HSA taxation in your state.

THE HRA AND HSA, SIDE BY SIDE		
	HRA	HSA
ACCOUNT SETUP	The plan funds the account (effective January 1) and BCBS manages it for you. You can view your account balance on bcbsil.com .	Discover sets up the account with ConnectYourCare (effective January 1). Once your account is open, you manage it through connectyourcare.com .
DISCOVER CONTRIBUTION	Same for both the HRA and HSA: \$400, \$700 or \$1,000, depending on the coverage you choose.	
TIMING OF DISCOVER CONTRIBUTION	Funds are available on January 1. New hires and qualified life events: Funds are prorated quarterly after coverage takes effect.	Funds are contributed quarterly, beginning January 1. You will have access to the entire annual amount by October. New hires: HSAs are opened the first of the month after coverage takes effect. You will receive a prorated annual amount based on your date of hire. You must be actively employed and have an active account on the first day of a quarter in order to receive the Discover contribution for that quarter.
EMPLOYEE CONTRIBUTION	Not allowed (IRS rule).	For 2015, you can contribute up to \$3,350 (\$6,650 family) plus \$1,000 if you are age 55 or older and not enrolled in Medicare, less the amount Discover contributes. Minimum contribution: \$260 (\$10 per pay period). These amounts are subject to annual adjustment.
COVERED EXPENSES	Medical expenses only. HRA funds cannot be used for dental, vision or prescription drug expenses. You can set up a separate Health Care FSA for these expenses.	Medical, prescription drug, dental and vision expenses. HSA funds used for ineligible expenses may be subject to tax and penalty (IRS rule).

Continued on next page.

THE HRA AND HSA, SIDE BY SIDE		
	HRA	HSA
MEETING THE DEDUCTIBLE WITH DEPENDENTS	One family member can meet the individual deductible for coinsurance to begin on that member.	One family member or a combination of family members must meet the family deductible for coinsurance to begin for any family member.
ABILITY TO INVEST ACCOUNT FUNDS	No.	Yes. Investments have the potential to grow, tax-free, through earnings. Investment management fees apply.
FUND ROLLOVER AT YEAR-END	Yes, if you have a balance and you enroll in the HRA again the next year.	HSA funds are available year over year, even if you enroll in another medical plan.
PORTABILITY IF YOU LEAVE DISCOVER	No. HRA funds are only available to you if you are enrolled in the HRA through Discover.	Yes. You own the account and can use the money any time.

HSA Q&A

Do I have to set up my HSA?

No. Your HSA will be set up automatically after you enroll in the HSA Plan. HSA Bank will contact you directly if it needs to verify certain information before opening your account. You must have an open account for your payroll contributions and Discover's contributions to be deposited.

How will I receive Discover contributions?

You will receive quarterly contributions. The first contribution will be made around January 1 to initiate the account for the year. Other contributions will be made at the beginning of a calendar quarter, as soon as administratively possible. If you are a new hire, your first quarterly Discover contribution will be made at the beginning of the quarter following the effective date of your coverage. Your account must remain open to receive contributions, and you must be actively employed and have an active account at the beginning of a quarter in order to receive Discover contributions for that quarter.

Let's say I change from You Only to You + Spouse/Domestic Partner coverage during the current quarter. How is my quarterly contribution determined?

Discover's contribution will be based on your coverage level and employment status on the first day of the calendar quarter. In this case, you will receive \$175 (1/4 of \$700) in this quarter since you had You + Spouse/Domestic Partner coverage on the first day of the quarter.

Are Discover's contributions to my HSA taxable?

No, Discover's contributions are not taxable.

How much can I contribute to my HSA?

For 2015, you can contribute up to \$3,350 if you cover yourself or \$6,650 if you cover your family. If you are age 55 or older and not enrolled in Medicare, you can make additional "catch-up" contributions up to \$1,000 in 2015. Your maximum contribution amount is offset by the amount Discover contributes to your HSA. These amounts are subject to annual adjustment.

How do I make contributions to my HSA?

You can contribute two ways: When you enroll through myHR, you can elect to contribute pre-tax money from your paycheck to your HSA. Your contributions will be divided over the pay periods in the year and deducted from your paycheck. Your account must remain open to receive contributions. You can also make non-payroll contributions through your online HSA account. Non-payroll contributions are made post-tax but can be deducted at tax time.

How soon can I start using my HSA funds?

You can start the first week in January, after Discover makes the first quarterly contribution. If you are contributing as well, you should see your first payroll deduction deposited in your HSA in mid-January.

Can I change (increase or decrease) my HSA contribution during the year?

Yes. To change your contribution rate, go to myHR (resources.hewitt.com/discover) > Health and Insurance > Take Action > Health Savings Account Contribution Change. > Use the drop-down menu to choose “HSA Contribution Change” and follow the prompts.

How will I access my HSA funds?

You have a few options. You can use the health care payment card from ConnectYourCare to access your HSA funds. You can also transfer money or pay providers directly on the ConnectYourCare website. Or you can pay for eligible expenses with any other form of payment and request a withdrawal from your account.

Is the health care payment card a debit card?

No, it's a prepaid card. When paying for an eligible expense, swipe the card and select “credit.” There is no PIN (personal identification number) for your card, so be sure to keep track of your card to avoid misuse.

Can I also contribute to a Flexible Spending Account (FSA) if I enroll in the HSA plan?

Yes, you can contribute up to \$2,550 tax-free dollars from your pay, subject to annual adjustment, to a “limited purpose” Health Care FSA to pay for eligible dental and vision expenses, and eligible medical and prescription drug expenses incurred after you meet the HSA plan deductible.

If you are enrolled in a “general purpose” Health Care Flexible Spending Account (HCFSAs), and during the year enroll in the HSA plan, the type of HCFSAs you have will be affected. As long as your HCFSAs is administered by ConnectYourCare, once your HSA enrollment is processed, ConnectYourCare will automatically change your general purpose HCFSAs to a “limited purpose” FSA for any expenses/services effective as of your HSA enrollment and after. The HCFSAs will remain general purpose for expenses/services with dates of service prior to your HSA plan enrollment. If your general purpose HCFSAs is administered by another provider, you will be responsible for ensuring your HCFSAs is used as limited purpose only after your enrollment in the HSA plan.

What is the advantage of combining a limited-purpose Health Care FSA with an HSA?

Two reasons: First, the full amount of your annual FSA contribution is available immediately, even if you haven't contributed it all yet. Unlike FSA dollars, HSA dollars are available only when they are in the account. So if you have an eligible dental or vision expense early in the year, before your HSA is fully funded, you can use FSA dollars to pay for it. Second, using FSA dollars allows you to continue saving HSA dollars for future expenses. And both accounts are tax-free when you use the money for eligible expenses.

HRA Q&A

Do I have to set up my HRA?

No. Your HRA will be set up automatically after you enroll, and your funds will be available on January 1.

Can I contribute money to the HRA?

No, by IRS rule only the plan funds the HRA. You cannot contribute, too.

If I enroll in the HRA, can I also enroll in a health care Flexible Spending Account (FSA)?

Yes. You may contribute tax-free money from your paycheck to a separate Health Care FSA to reimburse yourself for expenses the HRA does not cover, such as your portion of the deductible. FSA-eligible expenses include medical, prescription drug, dental and vision expenses.

I'm enrolled in the HRA at the You + Spouse level. If I have a baby next July 1 and switch to You + Family, what will happen to my HRA?

The full amount will be available to you based on the coverage category you select and any additional amount will be prorated when your new coverage takes effect. In this case, you will have:

- \$700 of HRA funds (from You + Spouse coverage) for the 12 months from January 1 through December 31 plus
- An additional \$150 (half of \$300) for the six months from July 1 through December 31 (for a total of \$850 for You + Family coverage).

Can I use the HRA for eligible expenses incurred by my domestic partner and his/her dependent children?

Yes. You do not need to claim your domestic partner or his/her children as dependents on your tax return in order to use HRA dollars for their eligible expenses.

If I have a qualified life event and drop medical coverage after using all funds in my HRA, will you collect the funds back from me?

No, the total HRA contribution for the year is available to you on January 1, whether you are here for the full year or not. However, if you leave Discover or change medical plans, any balance in the account is forfeited (IRS rule).

What happens to a balance in my HRA if I switch to another medical plan next year?

The balance does not transfer to the other plan. An HRA balance only rolls over if you enroll in the HRA again.

If I have funds in my HRA and leave Discover, then get rehired, will my HRA balance be reinstated?

If you are rehired in the same calendar year you left, your balance will be reinstated if you enroll in the HRA plan. If you are rehired later, your balance will not be reinstated.

Where can I view my HRA balance?

On the BCBS website at **bcbsil.com**. Your balance also will appear on the Explanation of Benefits (EOB) you get from BCBS after processing a claim.

Regional Medical Program Options

The regional medical program options are offered to certain employees based on home zip code or work location. Each option includes prescription drug coverage, which may differ from the coverage available with the national Blue Cross Blue Shield medical options through CVS Caremark. All regional programs are fully insured and subject to state mandates.

For all regional plans, medical and prescription drug copays and medical deductibles apply to the annual out-of-pocket maximum.

The regional program options are described below. The preceding Schedule of Benefits and Exclusions sections for the national medical options do not apply to the regional medical program options. To obtain specific information about these programs and to determine which program options are available to you, view the Regional Medical Plan Features and Rates sheets and the Summary of Benefits and Coverage sheets on www.mydiscoverbenefits.com, or the Regional Medical Plan Summaries available as a supplement to the Welfare Benefits SPD. You can review the materials on the myHR website and also request hard copies by calling a myHR Service Center Representative or your regional medical program administrator directly.

HMSA Medical Plan

The HMSA Medical Plan is administered (and insured) by Hawaii Medical Service Association and is available to U.S. benefits-eligible employees living in Hawaii. Refer to the HMSA Guide to Benefits and the Benefit Plan Summary on myHR for additional information.

The HMSA Medical Plan offers you the freedom to select from a network of participating providers (in-network) or from any health care provider (out-of-network) each time you or your covered dependents require medical services.

Certain alternative treatments such as chiropractic, acupuncture and massage therapy are also covered and provided by HMSA.

SelectHealth (HMO)

SelectHealth is available to U.S. benefits-eligible employees living in Utah and requires you to receive medical care from a network of doctors and hospitals. Refer to the SelectHealth Certificate of Coverage on myHR for additional information.

You are not required to select a Primary Care Physician (PCP). HMOs generally provide 100% coverage after a set schedule of copays. In return, the plans tend to be more “managed” than the national plans available. Certain services may require meeting a deductible.

SelectHealth (HSA)

SelectHealth is available to U.S. benefits-eligible employees living in Utah. You are not required to select a Primary Care Physician (PCP). HSAs generally have lower premiums but higher deductibles. Also, you can set up a special tax-advantaged bank account and contribute tax-free money from your pay to cover any eligible health care expenses. Refer to the “How the HSA Works” section and the SelectHealth Certificate of Coverage on myHR for additional information.

Kaiser (HMO)

Kaiser HMO is available to U.S. benefits-eligible employees living in Southern California and requires you to receive medical care from a network of doctors and hospitals. Refer to the Kaiser Evidence of Coverage and Benefits Summary on myHR for additional information.

You are not required to select a Primary Care Physician (PCP). HMOs generally provide 100% coverage after a set schedule of copays. In return, the plans tend to be more “managed” than the national plans available.

REGIONAL PRESCRIPTION MEDICAL PLAN FEATURES SELECTHEALTH HMO (UTAH ONLY) PLAN FEATURE (percentages show what plan pays)	
NETWORK	NON-NETWORK
DEDUCTIBLE (INDIVIDUAL/FAMILY)	
\$350/\$700	No coverage except emergencies or with SelectHealth approval
ANNUAL OUT-OF-POCKET MAXIMUM¹	
\$2,000/\$4,000	No coverage except emergencies or with SelectHealth approval
LIFETIME MAXIMUM	
Unlimited	No coverage except emergencies or with SelectHealth approval
WELLNESS CARE (SUBJECT TO PLAN FREQUENCY LIMITS)	
WELL BABY VISITS (GENERALLY UP TO AGE 3)	
100%, no copay	No coverage (see above)
OFFICE VISITS	
PCP/NON-SPECIALIST	
\$30 copay	No coverage (see above)
SPECIALIST	
\$40 copay	No coverage (see above)
HOSPITAL EMERGENCY ROOM (EMERGENCIES ONLY)	
FACILITY CHARGES (COPAY WAIVED IF ADMITTED)	
\$125 copay	\$125 copay
MOST OTHER MEDICAL SERVICES	
OTHER MEDICAL SERVICES	
90% covered (other copays may apply; e.g., \$250 in-patient hospital)	No coverage (see above)

REGIONAL PRESCRIPTION MEDICAL PLAN FEATURES SELECTHEALTH HSA (UTAH ONLY) PLAN FEATURE (percentages show what plan pays)	
NETWORK	NON-NETWORK
DEDUCTIBLE (INDIVIDUAL/FAMILY)	
You Only: \$400	You Only: \$400
You + Spouse/Partner: \$700	You + Spouse/Partner: \$700
You + Child(ren): \$700	You + Child(ren): \$700
You + Family: \$1,000	You + Family: \$1,000
ANNUAL OUT-OF-POCKET MAXIMUM¹	
\$3,000/\$6,000	No coverage except emergencies or with SelectHealth approval

Continued on next page.

¹ Medical plan deductibles and copays and prescription drug copays apply to the out-of-pocket maximum for all three regional plans.

REGIONAL PRESCRIPTION MEDICAL PLAN FEATURES SELECTHEALTH HSA (UTAH ONLY) PLAN FEATURE (percentages show what plan pays)	
NETWORK	NON-NETWORK
LIFETIME MAXIMUM	
Unlimited	No coverage except emergencies or with SelectHealth approval
WELLNESS CARE (SUBJECT TO PLAN FREQUENCY LIMITS)	
WELL BABY VISITS (GENERALLY UP TO AGE 3)	
100% covered	No coverage (see above)
OFFICE VISITS	
PCP/NON-SPECIALIST	
85% after deductible	No coverage (see above)
SPECIALIST	
85% after deductible	No coverage (see above)
HOSPITAL EMERGENCY ROOM (EMERGENCIES ONLY)	
FACILITY CHARGES (COPAY WAIVED IF ADMITTED)	
\$125 copay	\$125 copay
MOST OTHER MEDICAL SERVICES	
OTHER MEDICAL SERVICES	
85% after deductible	No coverage (see above)

REGIONAL PRESCRIPTION MEDICAL PLAN FEATURES HMSA MEDICAL PLAN (HAWAII ONLY) PLAN FEATURE (percentages show what plan pays)	
NETWORK	NON-NETWORK
DEDUCTIBLE (INDIVIDUAL/FAMILY)	
Not applicable	\$100/\$300
ANNUAL OUT-OF-POCKET MAXIMUM¹	
\$2,500/\$7,500	\$2,500/\$7,500
LIFETIME MAXIMUM	
Unlimited	Unlimited
WELLNESS CARE (SUBJECT TO PLAN FREQUENCY LIMITS)	
WELL BABY VISITS (GENERALLY UP TO AGE 3)	
100% covered, subject to limits	70% of R&C ² after deductible
OFFICE VISITS	
PCP/NON-SPECIALIST	
85% after deductible	No coverage (see above)

Continued on next page.

¹ Medical plan deductibles and copays and prescription drug copays apply to the out-of-pocket maximum for all three regional plans.

² Reasonable and customary (R&C) fees.

REGIONAL PRESCRIPTION MEDICAL PLAN FEATURES HMSA MEDICAL PLAN (HAWAII ONLY) PLAN FEATURE (percentages show what plan pays)	
NETWORK	NON-NETWORK
SPECIALIST	
100% after \$12 copay	70% of R&C ¹ after deductible
HOSPITAL EMERGENCY ROOM (EMERGENCIES ONLY)	
FACILITY CHARGES (COPAY WAIVED IF ADMITTED)	
80% of eligible charges	80% of eligible charges
MOST OTHER MEDICAL SERVICES	
OTHER MEDICAL SERVICES	
90% covered	70% of R&C ¹ after deductible

REGIONAL PRESCRIPTION MEDICAL PLAN FEATURES KAISER HMO (SO. CALIFORNIA ONLY) PLAN FEATURE (percentages show what plan pays)	
NETWORK	NON-NETWORK
DEDUCTIBLE (INDIVIDUAL/FAMILY)	
None	No coverage
ANNUAL OUT-OF-POCKET MAXIMUM²	
\$1,500/\$3,000	No coverage
LIFETIME MAXIMUM	
Unlimited	No coverage
WELLNESS CARE (SUBJECT TO PLAN FREQUENCY LIMITS)	
WELL BABY VISITS (GENERALLY UP TO AGE 3)	
100%, no copay	No coverage
OFFICE VISITS	
PCP/NON-SPECIALIST	
\$20 copay	No coverage
SPECIALIST	
\$20 copay	No coverage
HOSPITAL EMERGENCY ROOM (EMERGENCIES ONLY)	
FACILITY CHARGES (COPAY WAIVED IF ADMITTED)	
\$150 copay	No coverage
MOST OTHER MEDICAL SERVICES	
OTHER MEDICAL SERVICES	
Varies by service; check with plan	No coverage

¹ Reasonable and customary (R&C) fees.

² Medical plan deductibles and copays and prescription drug copays apply to the out-of-pocket maximum for all three regional plans.

REGIONAL PRESCRIPTION DRUG PLAN FEATURES	
SELECTHEALTH HMO (UTAH ONLY)	
PLAN FEATURE (percentages show what plan pays)	
NETWORK	NON-NETWORK
RETAIL, 30-DAY SUPPLY	
GENERIC	
\$10 copay	No non-network coverage
PREFERRED BRAND	
\$20 copay	No non-network coverage
NON-PREFERRED BRAND	
\$45 copay (generic required)	No non-network coverage
MAIL ORDER, 90-DAY SUPPLY	
GENERIC	
\$10 copay	No non-network coverage
PREFERRED BRAND	
\$40 copay	No non-network coverage
NON-PREFERRED BRAND	
\$90 copay (generic required)	No non-network coverage

REGIONAL PRESCRIPTION DRUG PLAN FEATURES	
SELECTHEALTH HSA (UTAH ONLY)	
PLAN FEATURE (percentages show what plan pays)	
NETWORK	NON-NETWORK
RETAIL, 30-DAY SUPPLY	
GENERIC	
85% after deductible	No coverage
PREFERRED BRAND	
85% after deductible	No coverage
NON-PREFERRED BRAND	
85% after deductible	No coverage
MAIL ORDER, 90-DAY SUPPLY	
GENERIC	
85% after deductible	No coverage
PREFERRED BRAND	
85% after deductible	No coverage
NON-PREFERRED BRAND	
85% after deductible	No coverage

REGIONAL PRESCRIPTION DRUG PLAN FEATURES	
HMSA MEDICAL PLAN ¹ (HAWAII ONLY)	
PLAN FEATURE (percentages show what plan pays)	
NETWORK	NON-NETWORK
RETAIL, 30-DAY SUPPLY	
GENERIC	
\$7 copay	\$7 copay plus 20% of remaining eligible charge
PREFERRED BRAND	
\$30 copay	\$30 copay plus 20% of remaining eligible charge
NON-PREFERRED BRAND	
\$30 copay plus \$45 other brand name cost share	\$30 copay plus \$45 other brand name cost share and 20% of remaining eligible charge
MAIL ORDER, 90-DAY SUPPLY	
GENERIC	
\$11 copay	Not applicable
PREFERRED BRAND	
\$65 copay	Not applicable
NON-PREFERRED BRAND	
\$65 copay plus \$135 other brand name cost share	Not applicable

REGIONAL PRESCRIPTION DRUG PLAN FEATURES		
KAISER HMO (SO. CALIFORNIA ONLY)		
PLAN FEATURE (percentages show what plan pays)		
NETWORK		NON-NETWORK
RETAIL, 30-DAY SUPPLY		
GENERIC		
30-day supply	\$10 copay	No coverage
31-to-60-day supply	\$20 copay	
61-to-100-day supply	\$30 copay	
PREFERRED BRAND		
30-day supply	\$35 copay	No coverage
31-to-60-day supply	\$70 copay	
61-to-100-day supply	\$105 copay	
NON-PREFERRED BRAND		
Not applicable		

Continued on next page.

¹ A separate out-of-pocket maximum applies for prescription drugs under the HMSA Medical Plan.

REGIONAL PRESCRIPTION DRUG PLAN FEATURES		
KAISER HMO (SO. CALIFORNIA ONLY)		
PLAN FEATURE (percentages show what plan pays)		
NETWORK		NON-NETWORK
MAIL ORDER, 90-DAY SUPPLY		
GENERIC		
30-day supply	\$10 copay	No coverage
31-to-100-day supply	\$20 copay	
PREFERRED BRAND		
30-day supply	\$35 copay	Not applicable
31- to 100-day supply	\$70 copay	
NON-PREFERRED BRAND		
Not applicable		

Prescription Drug Coverage

Prescription drug benefits are part of your medical program coverage.

If you participate in a regional medical plan option, prescription drug benefits are provided through the regional medical options and may differ from the coverage in the national program options.

Refer to the appropriate regional program administrator for prescription drug coverage information.

If you participate in a Blue Cross Blue Shield option, CVS Caremark administers your prescription drug coverage as described in this section.

CVS Caremark Prescription Drug Program

The CVS Caremark prescription drug program includes a “generic” and “preferred” feature. Some prescription drugs have two names: the trademark or brand name and the chemical or generic name. By law, both brand name drugs and generic drugs must contain the same active ingredients and must meet the same standards for safety, strength and quality. Inactive ingredients, such as dyes, fillers and preservatives, may vary.

Preferred drugs, also referred to as “formulary,” are brand name drugs placed on CVS Caremark’s preferred list. When your prescription is filled with a generic drug, your cost share of the prescription usually will be at the lowest rate. When you have a preferred drug prescription filled, your share of the cost will be less than if you choose a brand-name drug prescription that is not on the preferred list.

For certain brand-name drugs, prior authorization may be required before dispensing from mail order or pharmacy.

Note: Formulary changes occur from time to time. The formulary can be found on Caremark’s website at **caremark.com**. If there are changes to the drugs you or your dependents take, you will be notified in writing by CVS Caremark. Changes could impact your costs.

Additional information about the prescription drug program, including information regarding the formulary, to order refills or locate a retail pharmacy, is available at **caremark.com** or by calling CVS Caremark’s Member Services at **888-739-7987**.

Prescription Drug Step Therapy

To help you save on prescription costs, you will be required to first try a generic medication before you can receive coverage for certain brand name medications. Not all brand medications are impacted, and in some cases, there are selected preferred brand drugs available that do not require use of a generic first. If you try (or have tried in the last 24 months) a generic drug and it does not work for you, then you may receive coverage for a brand-name drug that your doctor prescribes.

All prescription drugs will be dispensed in generic versions, if available. You may buy preferred or non-preferred drugs if you like, but if a generic version is available, you will pay the copay plus the difference in cost.

If no generic version is available, you will pay the copay for the preferred or non-preferred drug. Ultimately, you and your doctor decide which drug is right for you.

Additional information about the prescription drug program—including information regarding the formulary, step therapy, ordering refills or locating a retail pharmacy—is available at **caremark.com** or by calling CVS Caremark's Member Services at **888-739-7987**.

Eligible prescription drug expenses are not subject to a deductible, unless you are a participant in the HSA plan. Prescription drug copayments and coinsurance do not count toward annual coinsurance limits or deductibles, except for the HSA plan.

Mail-order (home delivery) services allow you to receive up to a 90-day supply of your prescription and usually reduce your out-of-pocket expenses. There is no copayment for generic prescription drugs through the Mail-Order service, except for the HSA plan, where you must first meet the plan deductible.

Specialty Medications

Specialty medications treat complex conditions like multiple sclerosis, cancer, rheumatoid arthritis, or hemophilia. These medications are very costly and typically require special handling. They may need to be refrigerated or delivered quickly. Due to the delicate nature of these medications and specialty drugs, certain medicines will be limited to a 30-day supply through mail order. The full mail order copay will apply to your 30-day supply.

SCHEDULE OF BENEFITS PRESCRIPTION DRUGS

PRESCRIPTION DRUG COST

Notes: Formulary changes occur from time to time. The formulary can be found on Caremark's website at **caremark.com**. If there are changes to the drugs you or your dependents take, you will be notified in writing by CVS Caremark. Changes could impact your costs.

A complete list of prescription drugs covered through CVS Caremark is available at **caremark.com**.

	RETAIL	MAIL ORDER
GENERIC		
PPO	\$5 copay for 30-day supply	\$5 copay up to 90-day supply
HRA	\$5 copay for 30-day supply	\$5 copay up to 90-day supply
HSA	15% coinsurance after deductible	100% covered after deductible; deductible does not need to be met for preventive generics as defined by CVS Caremark

Continued on next page.

SCHEDULE OF BENEFITS PRESCRIPTION DRUGS

PRESCRIPTION DRUG COST

Notes: Formulary changes occur from time to time. The formulary can be found on Caremark's website at caremark.com. If there are changes to the drugs you or your dependents take, you will be notified in writing by CVS Caremark. Changes could impact your costs.

A complete list of prescription drugs covered through CVS Caremark is available at caremark.com.

	RETAIL	MAIL ORDER
PREFERRED BRAND		
PPO	25% coinsurance (\$35 minimum/\$100 maximum), 30-day supply	25% coinsurance (\$70 minimum/\$200 maximum) up to 90-day supply
HRA	25% coinsurance (\$35 minimum/\$100 maximum), 30-day supply	25% coinsurance (\$70 minimum/\$200 maximum) up to 90-day supply
HSA	15% coinsurance after deductible	15% coinsurance after deductible
NON-PREFERRED BRAND		
PPO	45% coinsurance (\$50 minimum/\$160 maximum), 30-day supply	45% coinsurance (\$100 minimum/\$320 maximum), 90-day supply
HRA	45% coinsurance (\$50 minimum/\$160 maximum), 30-day supply	45% coinsurance (\$100 minimum/\$320 maximum) up to 90-day supply
HSA	25% coinsurance after deductible	25% coinsurance after deductible
SPECIALTY DRUG* (MAY REQUIRE APPROVAL, CONTACT CAREMARK)		
PPO	Preferred: 25% coinsurance (\$70 minimum/\$200 maximum) Non-Preferred: 45% coinsurance (\$100 minimum/\$320 maximum) Limited to a 30-day supply*	Not covered
HRA	Preferred: 25% coinsurance (\$70 minimum/\$200 maximum) Non-Preferred: 45% coinsurance (\$100 minimum/\$320 maximum) Limited to a 30-day supply*	Not covered
HSA	Preferred: 15% coinsurance after deductible Non-Preferred: 25% coinsurance after deductible	Not covered
ANNUAL OUT- OF-POCKET MAXIMUM (INDIVIDUAL/FAMILY)¹		
PPO	\$4,600/\$9,200 separate from medical	
HRA	\$3,600/\$7,200 separate from medical	
HSA	\$3,000/\$6,000 integrated with medical	

¹ A separate annual out-of-pocket maximum applies for prescription drugs under the PPO and the HRA plans. For the HSA plan, the out-of-pocket maximum for prescription drugs is integrated with the medical plan out-of-pocket maximum.

Prescription Drug Exclusions and Limitations

The following items are not covered (or have limitations, if indicated) under the prescription drug portion of the national medical plan options:

- Over-the-counter medications
(for example, any drug for which federal law does not require the prescription to bear the following statement: “Caution: federal law prohibits dispensing without prescription.”)
- Devices for respiratory therapy, ostomy supplies or other pharmacy devices
(colonoscopy prep is considered an eligible expense.)
- Hair loss prescriptions (for example, Propecia)
- Renova
- Erectile dysfunction prescriptions (for example, Viagra) limited to 10 units per 30-day supply
- Vitamins (for purposes other than prenatal), minerals and food supplements. Prescription strength vitamin D and folic acid are considered eligible expenses.
- Infant formula or nutritional supplements (unless preauthorized and necessary to treat a metabolic condition) or when used directly to treat and control symptoms and progression of an illness or disease (Refer to “Exclusions” for more details)
- Growth hormones over the age of 17
- Fertility drugs limited to \$10,000 lifetime maximum plan benefit per covered person
- Diet medications (for example, Meridia, Xenical) available only through mail order with pre-authorization

A diagnosis is required for certain specialty medications associated with growth deficiency disorders, the treatment of psoriasis, hepatitis C, severe allergic asthma and rheumatoid arthritis; authorization may also be required. Approval is based on the application of currently accepted medical guidelines and consensus statements for the appropriate use of the medication in the specific disease state.

For prescription expenses incurred outside of the United States, prescriptions will be reimbursed at 70% of R&C based on the exchange rate at the time the prescription is filled. Submit the receipt with a claim form to:

CVS Caremark
P.O. Box 686005
San Antonio, TX 78268-6005

CVS Caremark may contact your doctor to discuss the appropriateness of therapy and request consideration of a preferred drug or generic equivalent. This may result in your doctor prescribing a different dosage or brand name product or generic in place of your original prescription.

CVS Caremark will not change your prescription without written consent from your doctor. As always, it is up to you and your physician to determine the most appropriate drug for you.

Medicare

If you are eligible for Medicare and are still actively working, you are entitled to the same Discover health benefits offered to other employees. In this case, if you elect Medicare coverage, Medicare is the “secondary payer,” paying only for some charges if not covered by the Discover plan. These rules apply to your spouse/domestic partner and eligible dependents if he/she is covered under the Discover medical program and is not disabled, and you are still working, regardless of your age.

Note: If you are actively working and covered under the Discover medical program and your dependent is Medicare-eligible due to disability, Medicare pays first for that dependent.

CRITICAL ILLNESS INSURANCE

What is critical illness insurance?

Critical illness insurance provides you with a lump-sum payment in the event a covered family member* is diagnosed with one of the following medical conditions (as they are defined by the group certificate):

- Full benefit cancer¹
- Partial benefit cancer^{1, 2}
- Heart attack
- Stroke³
- Coronary artery bypass graft
- Kidney failure
- Alzheimer's disease⁴
- 22 other listed conditions⁵

Note: A major organ transplant benefit is also included. You will receive an additional lump-sum payment of 100% of your initial benefit amount for major organ transplant. This coverage would be in addition to the total benefit amount payable for the previously mentioned covered conditions.

How can this coverage benefit me?

Despite having comprehensive medical insurance, there are still expenses associated with a critical illness that many medical plans may not be designed to pay, such as copays, deductibles, out-of-network treatments, prescription drug copays, childcare, mortgage and utility payments.

How does critical illness insurance work?

Your initial benefit provides a lump-sum payment upon the first diagnosis of a covered condition. Recurrence benefit⁶ is paid when a covered person is diagnosed with another occurrence of the same covered condition for which an initial benefit was previously paid.

The maximum amount that you can receive through your critical illness plan is called the total benefit and is three times the amount of our initial benefit. This means that you can receive multiple initial benefit and recurrence benefit payments until you reach the maximum of 300% or \$60,000 (see payment example).

*Covered family member means all covered persons as defined in the certificate.

¹ Please review the Outline of Coverage/Disclosure Document for specific information about cancer benefits.

² MetLife critical illness insurance will pay 25% of the initial benefit amount for partial benefit cancer.

³ In certain states, the covered condition is severe stroke.

⁴ Please review the Disclosure Statement for specific information about Alzheimer's disease.

⁵ MetLife critical illness insurance will pay 25% of the initial benefit amount for each of the 22 listed conditions until the total benefit amount is reached. A covered person may only receive one payment for each listed condition in his/her lifetime. The listed conditions are: Addison's disease (adrenal hypofunction); amyotrophic lateral sclerosis (Lou Gehrig's disease); cerebrospinal meningitis (bacterial); cerebral palsy; cystic fibrosis; diphtheria; encephalitis; Huntington's disease (Huntington's chorea); Legionnaire's disease; malaria; multiple sclerosis (definitive diagnosis); muscular dystrophy; myasthenia gravis; necrotizing fasciitis; osteomyelitis; poliomyelitis; rabies; sickle cell anemia (excluding sickle cell trait); systemic lupus erythematosus (SLE); systemic sclerosis (scleroderma); tetanus; and tuberculosis.

⁶ There is a benefit suspension period between recurrences. The length of the benefit suspension period varies by state. MetLife will not pay a recurrence benefit for a covered condition that recurs during a benefit suspension period. MetLife will not pay a recurrence benefit for either a full benefit cancer or a partial benefit cancer unless the covered person has not had symptoms of, or been treated for, the full benefit cancer or partial benefit cancer for which MetLife paid an initial benefit during the benefit suspension period. A recurrence benefit is available for the following conditions: heart attack, stroke, coronary artery bypass graft, full benefit cancer and partial benefit cancer.

Does critical illness insurance replace my medical coverage?

Critical illness insurance is not intended to be a substitute for medical coverage providing benefits for medical treatment, including hospital, surgical and medical expenses. Critical illness insurance does not provide reimbursement for such expenses.

What are my coverage options?

You are automatically enrolled in \$3,000 of critical illness insurance if you are enrolled in the HRA or HSA national medical plan. You may also elect \$20,000 of critical illness insurance for yourself, spouse/domestic partner¹ and/or dependent children². Enrollment is guaranteed provided the employee is actively at work.

What are the pre-existing condition exclusions?

A pre-existing condition is a sickness or injury for which, in the three months before a covered person becomes insured under this certificate, medical advice, treatment or care was sought by such covered person, or recommended by, prescribed by or received from a physician or other practitioner of the healing arts. MetLife will not pay benefits for a covered condition that is caused by or results from a pre-existing condition in the covered condition occurs during the first six months that a covered person is insured under this certificate. This provision does not apply to benefits for the following covered conditions: heart attack or stroke.

How do I enroll?

To elect critical illness insurance for yourself and your dependents, access myHR when you are first eligible during annual enrollment or after experiencing a qualified life event that allows for enrollment.

Payment Example

The example below illustrates an employee who elected the initial benefit amount of \$20,000 and has a total benefit of three times (300%) the initial benefit amount or \$60,000.

ILLNESS—COVERED CONDITION	PAYMENT	TOTAL BENEFIT REMAINING
HEART ATTACK—FIRST DIAGNOSIS	Initial benefit payment of \$20,000 or 100%	\$40,000
HEART ATTACK—SECOND DIAGNOSIS, TWO YEARS LATER	Recurrence benefit payment of \$10,000 or 50%	\$30,000
KIDNEY FAILURE—FIRST DIAGNOSIS, THREE YEARS LATER	Initial benefit payment of \$20,000 or 100%	\$10,000

This example is for illustrative purposes only. The MetLife critical illness insurance policy and certificate are the governing documents with respect to all matters of insurance, including coverage for specific illnesses. The specific facts of each claim must be evaluated in conjunction with the provisions of the applicable policy and certificate to determine coverage in each individual case.

Additional Information

For additional information refer to the critical illness policy Disclosure Statement/Outline of Coverage (including the exclusions and limitations that apply to coverage) on myHR.

¹ Coverage for domestic partners, same-sex partners, civil union partners and reciprocal beneficiaries varies by state. Please contact MetLife for more information.

² Dependent child coverage varies by state. Please contact MetLife for more information.

DENTAL PROGRAM

The Discover dental program encourages regular dental checkups and helps pay the cost of your dental care.

- The dental program is comprised of the MetLife dental program—standard and premier options.
- The MetLife dental program offers you the freedom to select any dentist at any time and pays a portion of your cost. However, if you use a dentist participating in MetLife’s preferred dentist program (PDP), your out-of-pocket expenses will be lower.
- The dental program helps pay for many common dental treatments including exams, X-rays, cleanings, fillings and root canals. The dental program also provides limited coverage for bridgework, crowns, periodontics and orthodontic expenses.
- When you lose coverage under the dental program, you and your eligible dependents may have an opportunity to continue coverage (at your own expense) under COBRA for a period of time. See the “Continuation Coverage Rights Under COBRA” section for details.

MetLife Dental Program

The MetLife dental program offers you two levels of dental coverage—the standard option and the premier option. Both options offer you the freedom to choose from a network of participating dentists or from any dentist you choose, subject to various reimbursement schedules. For additional information, refer to: the MetLife Dental Certificate of Insurance for the Premier Option; MetLife Dental Certificate of Insurance for the Standard Option, and the MetLife Dental Certificate of Insurance for Louisiana, Mississippi and Montana found on myHR.

Preferred Dentist Program (PDP)

The MetLife dental program includes access to MetLife’s preferred dentist program (PDP)—a national provider network of over 200,000 dentists. All PDP dentists must meet MetLife’s standards for licensing, education, practice history and emergency coverage to be accepted into the network.

When you or a covered dependent receive services from a PDP dentist, you do not need to meet a deductible, your out-of-pocket expenses are reduced to pre-negotiated rates and your annual benefit maximum is greater than if you use a non-PDP dentist.

A list of PDP dentists is available under Find a Dentist on [metlife.com/mybenefits](https://www.metlife.com/mybenefits).

Non-PDP Dentist

When you or a covered dependent receive services from a dentist who does not participate in MetLife’s PDP Plus network (a non-PDP dentist), you must meet your annual deductible of \$100 per person (\$300 maximum) under the standard option or \$50 per person (\$150 maximum) under the premier option before the plan pays benefits. The deductible is waived for Type A services (see the “Covered Dental Expenses” section) under both options. Once you meet your annual deductible, the plan pays a portion of the Reasonable and Customary (R&C) charge under both options as shown in the table:

METLIFE DENTAL PLAN REIMBURSEMENT SCHEDULE			
STANDARD OPTION		PREMIER OPTION¹	
PDP SERVICES	NON-PDP SERVICES	PDP SERVICES	NON-PDP SERVICES
DEDUCTIBLE (INDIVIDUAL/FAMILY)			
\$0	\$100/\$300 ²	\$0	\$50/\$150 ²
TYPE A SERVICE (DIAGNOSTIC AND PREVENTIVE CARE)			
100%	50% of Reasonable and Customary (R&C), no deductible	100%	100% of R&C, no deductible
TYPE B SERVICE (RESTORATIVE SERVICES)			
80% of discounted fee	40% of R&C, after deductible is met	80% of discounted fee	80% of R&C, after deductible is met
TYPE C SERVICE (PROSTHOADONTICS)			
50% of discounted fee	25% of R&C, after deductible is met	50% of discounted fee	50% of R&C, after deductible is met
ORTHODONTICS			
50% of discounted fee, up to \$3,000 lifetime benefit maximum per child (children only)	25% of R&C after deductible, up to \$1,000 lifetime benefit maximum per person (children only)	50% of discounted fee, up to \$3,000 lifetime benefit maximum per person (children and adults)	50% of R&C after deductible, up to \$3,000 lifetime benefit maximum per person (children and adults)
ANNUAL BENEFIT MAXIMUM PER PERSON³			
\$3,000	\$2,000	\$3,000	\$2,000

Once enrolled, log on to metlife.com/mybenefits to review available benefits, see detailed plan information, download a claim form and track your claim status and history.

Covered Dental Expenses

The following are covered dental expenses under all options, unless otherwise noted. Exclusions and limitations are listed in the “Exclusions and Limitations” section.

Covered Type A dental expenses

include the following diagnostic and preventive services:

- Oral exams twice per calendar year
- Prophylaxis (scaling and cleaning of teeth) twice per calendar year
- Space maintainers for eligible children under age 19
- Fluoride treatments for eligible children under age 19 (once per calendar year)
- Sealants on first, second and permanent molars for eligible children under age 19 (one application per tooth per lifetime)
- Full-mouth X-rays (not more than one series in 36 consecutive months)

¹ In accordance with state insurance laws, some states, including Louisiana, Mississippi, Montana and Texas, may require that out-of-network expenses be treated the same as in-network expenses. Additionally, residents of Louisiana, Mississippi, Montana and Texas are limited to the Premier option.

² Deductible waived for Type A services.

³ In no event can any one person receive more than \$3,000 in benefits during a calendar year (excluding orthodontic services), even if provided by a PDP dentist.

- Bitewing X-rays (for the standard option, not more than one supplementary set per calendar year for adults, and two sets per calendar year for children under age 19; for the premium option, not more than two sets per year for children and adults)
- Emergency treatment to alleviate pain
- Periodontal maintenance (not more than two times a year in conjunction with prophylaxis or four times a year without regular prophylaxis)

Covered Type B dental expenses

include the following minor restorative services:

- Fillings (amalgam, silicate, acrylic or composite on molars)
- Extractions
- Oral surgery
- Periodontal services—supporting tissues of the teeth
- General anesthesia given in connection with covered dental services and subject to medical necessity
- Root canal therapy
- Injection of antibiotic drugs
- Inlays and onlays premier plan only when other restorative materials cannot be used (replacement limitation—not more than once every five years)
- Recement inlays/onlays

Covered Type C dental expenses

include the following prosthodontic services:

- Crowns (replacement limitation—not more than once every five years)
- Repair of crowns and bridgework (restoration limitation—not more than once in 36 months)
- Initial installation of fixed bridgework
- Initial installation of partial or full removable dentures (including adjustment within six months)
- Addition of teeth to a partial removable denture or bridgework to replace natural teeth
- Replacement of a non-serviceable denture or bridgework if such denture or bridgework was installed more than 5 years prior to replacement
- Replacement of an immediate, temporary, full denture or bridgework with a permanent, full denture or bridgework, if the immediate, temporary, full denture or bridgework cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full denture or bridgework
- Gold fillings (replacement limitation – not more than once every five years)
- Inlays and onlays standard plan only when other restorative materials cannot be used (replacement limitation—not more than once every five years)
- Implantology—reconstruction of missing teeth and their supporting structures with natural or synthetic (alloplastic, allogenic or autogenous) substitutes
- Recement of crowns or bridges

Orthodontic treatment generally consists of initial placement of an appliance and periodic follow-up visits.

Orthodontic services

include the following dental expenses:

- Treatment required to straighten teeth, subject to a lifetime maximum of \$3,000 per child in network (Standard Option) or \$3,000 per person in network (Premier Option)
- Appliance for Temporomandibular Joint (TMJ) disorder is covered and applied toward the orthodontic maximum
- The benefit payable for the initial placement will not exceed 20% of the maximum benefit amount for orthodontia
- The benefit payable for the periodic follow-up visits will be payable on a quarterly basis during the course of the orthodontic treatment if:
 - Dental Insurance is in effect for the person receiving the orthodontic treatment; and
 - Proof is given to MetLife that the orthodontic treatment is continuing
- If the initial placement was made prior to this dental insurance being in effect, the benefit payable will be reduced by the portion attributable to the initial placement:
 - The periodic follow-up visits commenced prior to this dental insurance being in effect
 - The number of months for which benefits are payable will be reduced by the number of months of treatment performed before this dental insurance was in effect; and
 - The total amount of the benefit payable for the periodic visits will be reduced proportionately

Pre-Determination of Benefits

When you or your covered dependents require dental care and treatment, you should discuss the treatment and cost with your dentist in advance.

If treatment is expected to cost \$300 or more, you should have your dentist fill out a pretreatment estimate (on the dental claim form), which describes the services proposed by your dentist and the charges for these services. Then, you or your dentist should forward the completed form to MetLife. The proposed course of treatment will be reviewed by MetLife and you will be informed in advance how much the plan will pay before the work actually begins. If the procedure for which you received a pretreatment estimate is not followed or if the verifying information required by MetLife is incomplete, the benefits paid will be based only on available information about your treatment. This could result in a smaller benefit than would otherwise be paid. **If you choose not to submit a pretreatment estimate, you take the risk that your procedure may be reimbursed at a lower rate than you expect.**

Alternate Courses of Treatment

Dental procedures can vary greatly in expense. If there is more than one suitable procedure for your particular problem, the plan will pay benefits for the least expensive procedure. If you and your dentist elect to use a more expensive procedure or material than that provided for by the plan, you will be required to pay the difference between the costs of the procedure actually provided and costs normally covered for the less expensive procedure or material. Dental consultants review pretreatment estimates and claim forms to determine whether alternate courses of treatment that meet generally accepted standards of care would provide a satisfactory result at a lower cost.

Exclusions and Limitations

The plan does not cover some dental expenses. These include but are not limited to:

- Cosmetic services and supplies, such as bleaching
- Precision or other elaborate attachments or features for dentures, bridgework or any other dental appliance (standard plan only)
- Replacement of a lost, missing or stolen prosthetic device or appliance
- Any duplicate prosthetic device or appliance
- Dentures, crowns, inlays, onlays and bridgework or other appliances or services to increase vertical dimension
- Services or supplies that are not appropriate or do not meet generally accepted standards of dental care as determined by MetLife
- Missed appointments
- Any dental service or supplies included as covered expenses under any other Discover benefit plan
- Treatment by a provider other than a dentist (except the cleaning or scaling of teeth and topical application of fluoride performed by a licensed dental hygienist under the supervision of a dentist)
- Veneers on crowns or pontics on the molar teeth
- Oral hygiene instruction, plaque control programs and dietary instructions
- Bruxism (grinding the teeth), including bite guards
- Treatment of any jaw disorder, other than appliance therapy, which may be covered as an orthodontic expense. (Some expenses incurred due to accident or injury may be covered by the medical program. Review the Medical Program section or contact your health plan administrator for more information.)
- Treatment for Temporomandibular Joint (TMJ) disorder or other craniomandibular disorders, other than appliance therapy which is covered as an orthodontic expense
- Services or supplies provided because of service in the armed forces of any government
- Services or supplies which are normally provided free of charge
- Services or supplies not recommended and approved by the attending dentist or physician (experimental)
- Fabrication of athletic mouth guards
- Supplies which are temporary (for example, a temporary bridge)
- Charges in excess of R&C or that satisfy the deductible and annual maximums
- Services necessary because of acts of war or riot
- Services or supplies not medically necessary
- Periodontal splinting

Benefits will not be payable for treatment received before plan coverage begins. However, if treatment that had started before coverage begins is completed after the effective date of coverage, part of the cost may be covered, as determined by the dental program administrator, from the effective date of coverage.

Under the MetLife dental program, you are eligible to receive the discounted rate from a PDP provider for non-covered services, such as bleaching, subject to availability in your state. To receive the discounted rate, you must notify your provider that you participate in the MetLife PDP Plus program.

Dental Program Coordination of Benefits

When you or a dependent incurs charges for covered services, there may be other plans, as defined below, that also provide benefits for those same charges. In that case, MetLife may reduce what is paid based on what the other plans pay. This Coordination of Benefits section explains how and when this is done.

DEFINITIONS

In this section, the terms set forth below have the following meanings:

Allowable expense means

a necessary dental expense which both of the following are true:

- A covered person must pay it; and
- It is at least partly covered by one or more of the plans that provide benefits to the covered person.

If a plan provides fixed benefits for specified events or conditions (instead of benefits based on expenses incurred), such benefits are allowable expenses.

If a plan provides benefits in the form of services, we treat reasonable cash value of each service performed as both an allowable expense and a benefit paid by that plan.

The term does not include:

- Expenses for services performed because of a job-related injury or sickness;
- Any amount of expenses in excess of the higher reasonable and customary fee for a service, if two or more plans compute their benefit payments on the basis of reasonable and customary fees;
- Any amount of expenses in excess of the higher negotiated fee for a service, if two or more plans compute their benefit payments on the basis of negotiated fees; and
- Any amount of benefits that a primary plan does not pay because the covered person fails to comply with the primary plan's managed care or utilization review provisions, these include provisions requiring:
 - Second surgical opinions;
 - Pre-certification of services;
 - Use of providers in a plan's network of providers; or
 - Any other similar provisions.

Job-related injury or sickness means any injury or sickness:

- For which you are entitled to benefits under a workers' compensation or similar law, or any arrangement that provides for similar compensation; or
- Arising out of employment for wage or profit.

The provisions of this plan, which limit benefits based on benefits or services provided under government plans or plans that the policyholder (or an affiliate) contributes to or sponsors will not be affected by these coordination of benefits provisions.

Each policy, contract or other arrangement for benefits is a separate plan. If part of a plan reserves the right to reduce what it pays based on benefits or services provided by other plans, that part will be treated separately from any parts which do not.

This plan

means the dental benefits described in this certificate, except for any provisions in this certificate that limit insurance based on benefits for services provided under government plans, or plans which the policyholder (or an affiliate) contributes to or sponsors.

Primary plan

means a plan that pays its benefits first under the "Rules to Decide Which Plan Is Primary" section. A primary plan pays benefits as if the secondary plans do not exist.

Secondary plan

means a plan that is not a primary plan. A secondary plan may reduce its benefits by amounts payable by the primary plan. If there are more than two plans that provide coverage, a plan may be primary to some plans, and secondary to others.

Rules to Decide Which Plan Is Primary

When more than one plan covers the person for whom allowable expenses were incurred, MetLife determines which plan is primary by applying the rules in this section.

When there is a basis for claim under this plan and another plan, this plan is secondary unless:

- The other plan has rules coordinating its benefits with those of this plan; and
- This plan is primary under this plan's rules.

The first rule below, which will allow MetLife to determine which plan is primary, is the rule that MetLife will use.

Dependent or Non-Dependent:

A plan that covers a person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is primary and shall pay its benefits before a plan that covers the person as a dependent; except that if the person is a Medicare beneficiary and, as a result of federal law or regulations, Medicare is:

- Secondary to the plan covering the person as a dependent; and
- Primary to the plan covering the person as other than a dependent (e.g., a retired employee);

Then the order of benefits between the two plans is reversed and the plan that covers the person as a dependent is primary.

Child Covered Under More Than One Plan—Court Decree:

When this plan and another plan cover the same child as the dependent of two or more parents, and the specific terms of a court decree state that one of the parents must provide health coverage or pay for the child's health care expenses, that parent's plan is primary, if the plan has actual knowledge of those terms. This rule applies to claim determination periods that start after the plan is given notice of the court decree.

Child Covered Under More Than One Plan—The Birthday Rule:

When this plan and another plan cover the same child as the dependent of two or more parents, the primary plan is the plan of the parent whose birthday falls earlier in the year if:

- The parents are married; or
- The parents are not separated (whether or not they have ever married); or
- A court decree awards joint custody without specifying which parent must provide health coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is the primary plan.

However, if the other plan does not have this rule, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

Child Covered Under More than One Plan—Custodial Parent:

When this plan and another plan cover the same child as the dependent of two or more parents, if the parents are not married, or are separated (whether or not they ever married), or are divorced, the primary plan is:

- The plan of the custodial parent; then
- The plan of the spouse of the custodial parent; then
- The plan of the non-custodial parent; and then
- The plan of the spouse of the non-custodial parent.

Active or Inactive Employee:

A plan that covers a person as an employee who is neither laid off nor retired is primary to a plan that covers the person as a laid-off or retired employee (or as that person's dependent). If the other plan does not have this rule and, if as a result, the plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage:

The plan that covers a person as an active employee, member or subscriber (or as that employee's dependent) is primary to a plan that covers that person under a right of continuation pursuant to federal law (e.g., COBRA) or state law. If the plan that covers the person has not adopted this rule, and if, as a result, the plans do not agree on the order of benefits, this rule shall not apply.

Longer/Shorter Time Covered:

If none of the above rules determine which plan is primary, the plan that has covered the person for the longer time shall be primary to a plan that has covered the person for a shorter time.

No Rules Apply:

If none of the above rules determine which plan is primary, the allowable expenses shall be shared equally between all the plans. In no event will this plan pay more than it would if it were primary.

Effect on Benefits of This Plan

If this plan is secondary, MetLife will reduce the benefits that would otherwise be payable under this plan when the total allowable expenses incurred by a covered person in any claim determination period are less than the sum of:

1. The benefits that would be payable under this plan without applying this coordination of benefits provision, and
2. The benefits that would be payable under all other plans without applying coordination of benefits or similar provisions.

The sum of these reduced benefits, plus all benefits payable for such allowable expenses under all other plans, will not exceed the total of the allowable expenses. Benefits payable under all other plans include all benefits that would be payable if the proper claims had been made on time.

Right to Receive and Release Needed Information

MetLife needs certain information to apply the coordination of benefits rules. MetLife has the right to decide which facts are needed. MetLife may get facts from or give them to any other organization or person. MetLife does not need to tell, or get the consent of, any person or organization to do this. To obtain all benefits available, a covered person who incurs allowable expenses should file a claim under each plan that covers the person. Each person claiming benefits under this plan must give MetLife any facts it needs to pay the claim.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, MetLife may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. MetLife will not have to pay that amount again. The term "payment made" includes benefits provided in the form of services, in which case MetLife may pay the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount MetLife pays is more than should have been paid under this coordination of benefits provision, MetLife may recover the excess from one or more of:

- The person MetLife paid or for whom they have paid;
- Insurance companies; or
- Other organizations.

The amount of the payment includes the reasonable cash value of any benefits provided in the form of services.

To find out whether a specific type of service not listed above is covered, call MetLife at **800-942-0854**.

VISION PROGRAM

The Discover vision program encourages you to have regular vision exams and pays some or all of the costs associated with eyeglass lenses, frames and contact lenses. The vision program is fully insured by VSP Vision Care (VSP). Vision insurance coverage is summarized in VSP's evidence of coverage, which is a supplement to this SPD and can be found on myHR.

- The Discover vision program allows you the freedom to receive vision care services from a network of participating doctors (in-network) or from any vision care provider you choose (out-of-network).
- You can choose from two vision program options: standard and premier.
- Both vision programs help pay for expenses associated with eye care needs, including comprehensive exams, lenses and frames as well as a discount on laser vision surgery from participating doctors. The premier vision program also includes coverage of specialized lenses (including polycarbonate and polarized) and specialized lens treatments (including tinting, scratch resistant and anti-reflective coatings). When you lose coverage under the vision program, you and your eligible dependents may have an opportunity to continue coverage (at your own expense) under COBRA for a period of time. See the "Continuation Coverage Rights Under COBRA" section for details.

The vision program, administered by VSP, allows you to receive a variety of eye care services and supplies from VSP's network of participating vision care doctors (in-network) or from any eye care provider you choose (out-of-network). However, benefits are greatest and your out-of-pocket costs are reduced if you visit a doctor participating in the VSP network.

In-Network Benefits

The vision program provides access to VSP's network of over 31,000 vision care doctors (including both independent optometrists and ophthalmologists). All network doctors must meet VSP's standards for licensing, education, practice history and dispensing services to be accepted into the network.

A list of VSP network doctors is available without charge on the VSP website at **vsp.com** or by calling VSP customer service at **800-877-7195**. On the VSP website, click on "Prospective Members and Consumers" and "Find a Doctor." You can also search for a doctor on the myHR website (click on "Health and Welfare, Planning Tools" and "Find a Health Care Provider").

To receive services from a VSP network doctor, call the doctor and schedule an appointment, identify yourself as a VSP member through Discover and provide the office with your first and last name and date of birth.

There are no ID cards and claim forms to submit if you use a network doctor.

Out-of-Network Benefits

You and your covered dependents may use out-of-network providers for eligible eye care services and receive reimbursement up to the allowance (see the "Schedule of Benefits" section). You are responsible for all charges and you must submit a claim for reimbursement of expenses, up to the vision program maximum.

Claims for reimbursement must be submitted to VSP within 12 months, following the date of service.

Covered Vision Expenses

Eye Examinations

You and your covered dependents are eligible to receive a comprehensive eye examination with dilation (when professionally indicated) from a VSP network doctor once each calendar year for a \$15 copay. In-network eye examinations include the following procedures:

- Refractive care—distance and near
- Prescribing of eyeglasses
- Case history, including eye and vision history and medical history
- Distance and near acuities—habitual and/or uncorrected
- External ocular examination
- Internal ocular examination (including dilation where professionally indicated)
- Tonometry
- Binocular coordination evaluation—distance and near
- Patient education on matters pertaining to vision care

Fitting of Eyeglasses

If vision correction is recommended by a doctor, covered expenses include the fitting of eyeglasses and follow-up adjustment.

Eyeglass Lenses

You and your covered dependents are eligible to receive prescription eyeglass lenses from a VSP network doctor once in each calendar year. Covered lenses include glass or plastic lenses, in single vision, bifocal, trifocal or lenticular prescriptions. The premier plan also covers cosmetic lens enhancements.

Frames

You and your covered dependents are eligible to receive a retail allowance up to \$130 toward eyeglass frames of your choice from a VSP network doctor every two calendar years. For frames that exceed the \$130 retail allowance, you will receive a 20% discount on the difference. Frames purchased from a non-VSP provider are reimbursed up to \$50.

Contact Lenses

You and your covered dependents are eligible to receive contact lenses instead of glasses. An allowance of up to \$130 will be applied toward the cost of your contact lenses from the VSP network. The contact lens exam (fitting and evaluation) is covered separately with an up to \$60 copay. You and your covered dependents can find information about contact lens discounts at **vsp.com** under Rebates & Special Offers. Contact lenses are available once every calendar year in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, you will not be eligible for lenses or frames within the same calendar year.

When medically necessary contact lenses are obtained from a VSP network doctor, they will be covered in full with prior authorization from VSP. When medically necessary contact lenses are obtained from a non-VSP provider, VSP will provide an allowance of \$210 towards their cost. Coverage for medically necessary contact lenses regardless of whether they are obtained from a VSP network doctor or non-VSP provider are subject to review and authorization from VSP's optometric consultants.

Laser Vision Correction Surgery

You and your covered dependents are eligible to receive discounts that vary by location but will average 15% off the in-network laser center's usual and customary fee. Additionally, if the laser center is offering

a temporary price reduction, VSP members will receive 5% off the promotional price if it is less than the usual discounted price. To receive the laser vision correction surgery discount, participants must arrange for services through a participating VSP Laser VisionCare doctor. The maximum fee a member will pay through a participating provider is \$1,500 per eye for PRK, \$1,800 per eye for Lasik and \$2,300 per eye for custom Lasik.

You and your covered dependents are responsible for paying all fees directly to the center. The vision program does not assume any financial responsibility for the access to these discounts and will not reimburse you or your covered dependent if you are dissatisfied with the discount obtained. Therefore, you should determine the level of discount available and its acceptability prior to receiving services.

To find a VSP Laser VisionCareSM doctor near you, visit vsp.com or contact VSP's member services.

Diabetic Eyecare Plus Program

Plan benefits under the Diabetic Eyecare Plus Program (DEP) are available to covered persons who have been diagnosed with diabetic eye disease and specific ophthalmological conditions. The program does not cover medical treatment for covered persons with diabetic or any other medical conditions.

VSP network doctors will provide services under the program as needed following routine eye examination. No referrals or authorizations are required for services provided under the DEP.

A copayment of \$5 is required for each ophthalmological service and office visit and is paid at the time of service. Other copayments may apply to services under the VSP Plan. Refer to the VSP Plan Schedule of Benefits:

DIABETIC EYECARE PLUS PROGRAM (DEP) BENEFITS			
SERVICE	VSP NETWORK DOCTOR BENEFIT	BENEFIT FREQUENCY	NON-VSP PROVIDER BENEFIT
OPHTHALMOLOGICAL SERVICES AND OFFICE VISITS	Covered in full, less \$5 copayment	Once every 12 months	Up to current non-VSP provider schedule of allowances
GONIOSCOPY	Covered in full	Once every 12 months	Up to current non-VSP provider schedule of allowances
EXTENDED OPHTHALMOSCOPY	Covered in full	Once every 6 months ¹	Up to current non-VSP provider schedule of allowances
FUNDUS PHOTOGRAPHY	Covered in full	Once every 6 months ¹	Up to current non-VSP provider schedule of allowances

Exclusions and Limitations of DEP Benefits

The DEP covers diabetic eye care evaluation services only. There is no coverage provided under the plan for the following:

- Costs associated with securing frames, lenses or any other materials
- Orthotics or vision training and any associated supplemental testing
- Surgical procedures, including laser or any other form of refractive surgery, and any pre- or post-operative services
- Pathological treatment of any type for any condition

¹ Service and/or diagnosis limitations apply, or certain procedures require special handling. VSP Network Doctors must consult the VSP Provider Reference Manual for details before rendering services.

- Any eye examination required by an employer as a condition of employment
- Insulin or any medications or supplies of any type
- Services and/or materials not listed as covered plan benefits

Low Vision

You and your covered dependents are eligible to receive low vision services from VSP network doctors and non-VSP providers. Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for members' low vision.

After prior approval by VSP, covered low vision services include:

- Supplemental low vision testing (includes evaluation, diagnosis and prescription of vision aids where indicated) covered in full from a VSP network doctor or up to \$125 from a non-VSP provider.
- If low vision aids are approved, VSP covers 75% of the approved fee not to exceed \$1,000 every two years (less any amount paid for the supplemental testing) from either a VSP network doctor or non-VSP provider. The VSP member is responsible for the remaining 25%, plus any amount over the approved fee.

Exclusions and Limitations

The vision program does not cover some expenses. These include, but are not limited to:

- Lenses that do not provide vision correction
- Charges for the replacement of lost or stolen lenses or frames
- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (i.e., when a patient's refractive error is less than a +/-50 diopter power)
- Two pairs of glasses instead of bifocals
- Medical or surgical treatment of the eyes
- Replacement of lenses and frames furnished under this plan, except at the normal intervals when services are available
- Certain limitations on low vision care
- Expenses covered by any other group coverage
- Any eye examination or any corrective eye wear required by an employer as a condition of employment

Exclusions specific to contact lens coverage include but are not limited to:

- Corneal Refractive Therapy (CRT) or orthokeratology
- Replacement of lost or damaged lenses
- Insurance policies or service agreements
- Plano lenses (i.e., when a patient's refractive error is less than a +/-50 diopter power)
- Plano lenses to change eye color cosmetically
- Artistically painted lenses
- Additional office visits associated with contact lens pathology
- Contact lens modification, polishing or cleaning

Schedule of Benefits

Services are reimbursed differently based on the service provided and whether you receive services from an in-network doctor or out-of-network provider, as indicated in this chart:

FREQUENCY	VSP NETWORK PROVIDER		NON-VSP PROVIDER
	STANDARD OPTION	PREMIER OPTION	
EYE EXAM (INCLUDING DILATION, WHERE PROFESSIONALLY INDICATED)			
Once per calendar year	100% after \$15 copay	100% after \$15 copay for exam, frames and/or lenses combined	Up to \$30
EYEGLASS LENSES			
Once per calendar year	100% after \$25 copay for frames and/or lenses	100%	Single: Up to \$30 Bifocal: Up to \$40 Trifocal: Up to \$50 Lenticular: Up to \$60
OPTIONAL LENSES AND TREATMENTS, INCLUDING:			
<ul style="list-style-type: none">• Progressive• Photochromic• Scratch-resistant• Anti-reflective	<ul style="list-style-type: none">• High-index• Polarized• Polycarbonate	<ul style="list-style-type: none">• Ultraviolet coating• Blended segment• Rimless	<ul style="list-style-type: none">• Over-sized• Laminated• Edge treatments
Once per calendar year	Not covered	100%	N/A
FRAMES (ANY FRAME OF YOUR CHOICE)			
Once per two calendar years	Up to \$130 plus 20% discount on any out-of-pocket costs	Up to \$130 plus 20% discount on any out-of-pocket costs	Up to \$50
ELECTIVE CONTACT LENSES ¹ (IN LIEU OF EYEGLASS LENSES AND FRAMES)			
WHEN YOU CHOOSE CONTACT LENSES INSTEAD OF GLASSES, YOUR \$130 ALLOWANCE APPLIES TOWARDS THE COST OF YOUR CONTACT LENSES. YOU HAVE A SEPARATE CONTACT LENS EXAM (FITTING AND EVALUATION) UP TO A \$60 COPAY. THIS EXAM IS IN ADDITION TO YOUR VISION EXAM TO ENSURE PROPER FIT OF CONTACTS.			
Once per calendar year	\$130 allowance for contacts; copay does not apply. Contact lens exam (fitting and evaluation) with up to \$60 copay.	\$130 allowance for contacts; copay does not apply. Contact lens exam (fitting and evaluation) with up to \$60 copay.	Up to \$95
MEDICALLY NECESSARY LENSES ¹			
Once per calendar year	100% after \$25 copay	100% after \$25 copay	Up to \$210

Continued on next page.

¹ Pre-approval by VSP is required.

FREQUENCY	VSP NETWORK PROVIDER		NON-VSP PROVIDER
	STANDARD OPTION	PREMIER OPTION	
LASER VISION CORRECTION SURGERY ¹			
No limit	Discounts range from 10% to 25% (depending upon location) or 5% off any advertised discounted fee, whichever is lower	Discounts range from 10% to 25% (depending upon location) or 5% off any advertised discounted fee, whichever is lower	N/A
LOW VISION ¹ SUPPLEMENTAL TESTING (INCLUDES EVALUATION, DIAGNOSIS AND PRESCRIPTION AIDS WHERE INDICATED)			
Twice per two calendar years	100%	100%	Up to \$125
LOW VISION ² SUPPLEMENTAL AIDS UP TO \$1,000 EVERY TWO YEARS (COMBINED IN- AND OUT-OF-NETWORK)			
Once per two calendar years	75% of approved fee	75% of approved fee	75% of approved fee
EXTRA SAVINGS			
Available from any VSP doctor	Get 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP doctor within 12 months of your last WellVision Exam.	Get 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP doctor within 12 months of your last WellVision Exam.	N/A

FLEXIBLE SPENDING ACCOUNTS

The Flexible Spending Account (FSA) program allows you to direct a part of your pay, on a pre-tax basis, into special accounts that can be used throughout the year to reimburse you for certain out-of-pocket health care expenses for you or your eligible dependents (the Health Care Flexible Spending Account or HCFSA) or work-related day care expenses for your eligible dependents (the Dependent Day Care Flexible Spending Account or DDCFSA):

- You do not pay federal income tax, Social Security (FICA) tax, federal unemployment (FUCA) tax or most state and local income taxes on the money you contribute to the FSA program.
- Your accounts are subject to IRS and plan rules, which are explained on the following pages.
- It is important that you read this explanation before you decide whether to contribute to the FSA program.

¹ The maximum fee a member will pay is \$1,500 per eye for PRK, \$1,800 per eye for lasik, and \$2,300 per eye for custom lasik.

² Pre-approval by VSP is required.

How the FSA Program Works

The FSA program is comprised of three accounts:

- The Health Care Flexible Spending Account (HCFSAs) for reimbursing eligible health care expenses for you and your eligible dependents
- The “limited purpose” Health Care Flexible Spending Account for reimbursing eligible dental and vision expenses, and eligible medical and prescription drug expenses incurred after you meet the HSA plan deductible
- The Dependent Day Care Flexible Spending Account (DDCFSA) for reimbursing eligible day care expenses for your eligible dependents

Depending on your needs, you may decide to participate in an HCFSAs or the DDCFSA, or both an HCFSAs and the DDCFSA. If you participate in the HSA plan, you may participate in a limited purpose HCFSAs for reimbursing dental and vision expenses and/or medical and prescription drug expenses after you meet the HSA plan deductible. You may not transfer money between your HCFSAs and DDCFSA.

To participate, you must indicate the amount of pre-tax dollars you want to contribute for the calendar year. Tax laws contain restrictions that you should keep in mind when determining how much to contribute (see the “IRS Regulations” section). Once you make your elections, contributions to your accounts continue for the entire calendar year unless:

- You terminate employment with Discover
- You become ineligible to participate in the FSA program
- Your earnings are reduced to an amount less than your annual election
- Your contribution is reduced based on IRS nondiscrimination requirements (see the “IRS Rules” section), or
- You modify your coverage due to a qualified life event (see the “Qualified Life Events” section)

Contributing to Your Accounts

You can contribute between \$100 and \$2,550 annually to the HCFSAs or limited-purpose HCFSAs, and between \$100 and \$5,000 annually to the DDCFSA if you are single or married and filing a joint tax return, or between \$100 and \$2,500 annually to the DDCFSA if you are married and filing separate returns. Certain highly compensated employees may have their HCFSAs and/or DDCFSA contribution reduced to comply with IRS “nondiscrimination” rules. See the “IRS Rules” section for more information.

Federal tax law limits the amount of contributions to a DDCFSA to the lesser of your or your spouse’s earned income. If your spouse is not working but is a full-time student or is disabled, your spouse’s earned income is considered to be \$250 a month if you have one eligible dependent or \$500 monthly for two or more eligible dependents (see the “Definition of Eligible Dependents” section).

Contributions to these accounts are made on a pre-tax basis and therefore reduce your taxable income. Participation in the plan may reduce your contributions to Social Security, depending on your pay and the amount of your contribution, which may in turn reduce any Social Security benefits to which you may become entitled.

Your contributions to an FSA will not affect any salary-related Discover plans, such as the 401(k) Plan. If you choose not to make pre-tax contributions to the FSA program, you will be paid your compensation in cash each pay period over the plan year, subject to applicable federal income tax, Social Security (FICA) tax, federal unemployment (FUTA) tax and state and local income tax.

To open an account, you must indicate the amount you wish to put into the HCFSAs and/or the DDCFSA for the plan year when you enroll on the myHR website. It is important for you to budget your eligible expenses accurately, as the DDCFSA account is subject to the IRS “use it or lose it rule,” which could

result in a forfeiture of account balance not used within the applicable time frame. The HCFSa allows you to roll over up to \$500 into next year's HCFSa account. You should be careful to estimate your planned expenses to avoid losing any of your account balances at the end of the eligible expense period. Any forfeiture in FSA accounts will be used for the reasonable expense of maintaining and administering FSA accounts as permitted under applicable law.

How the Money Gets Into Your Accounts

When you elect to contribute to an FSA, you are directing Discover to reduce your compensation by the amount you elect. Your annual election is credited to your accounts through payroll deductions. The FSA program is administered by ConnectYourCare (CYC).

Direct Deposit Feature

You can register on the ConnectYourCare website at connectyourcare.com to have your FSA reimbursements deposited directly into your U.S. checking or savings account.

IRS Rules

Consider the following federal tax law restrictions as you make your contribution decisions:

- IRS “use it or lose it” rule: Any money in your DDCFSa that is not used for an eligible expense incurred by December 31 of the current plan year for eligible dependent day care expenses for the DDCFSa must be forfeited.
- Up to \$500 left in your HCFSa that is not used for an eligible expense incurred by December 31 of the current plan year will roll over into the new plan year. Anything above the \$500 must be forfeited due to the IRS “use it or lose it” rule. (Note: If you enroll in an HSA plan for the following year, your HCFSa will become a limited purpose HCFSa and the amounts rolled over will only be eligible for dental and vision expenses, and eligible medical and prescription drug expenses after you meet the HSA deductible for the new year.)
- You may submit claims for eligible expenses through March 31 of the following calendar year for the expenses incurred through December 31 of the current year.
- Only eligible expenses will be reimbursed through the FSA program. The FSA program will follow IRS guidelines in determining whether an expense is eligible as “medical care” as defined under Section 213 of the Internal Revenue Code. A complete list of tax-deductible health care expenses is available in IRS Publication 502 Medical and Dental Expenses. A complete list of tax-deductible dependent day care expenses is available in IRS Publication 503 Child and Dependent Care Expenses. To obtain copies, call 800-tax-form or visit the IRS website at irs.gov.
- Only eligible claims incurred while you are a participant will be reimbursed
- Reimbursements made in violation of the IRS rules may cause you to be subject to additional income taxes and penalties.
- Once you elect to participate in an FSA, your election will generally stay in effect for the remainder of the calendar year, as long as you remain an eligible employee (see the “Qualified Life Events” section).
- You may not transfer money between the HCFSa and DDCFSa.
- Discover is required to perform tests on the HCFSa and the DDCFSa to ensure this account does not favor participants who are considered highly compensated under federal tax law. If the tests are not satisfied, pre-tax contributions of higher paid employees may be reduced. If a reduction in pre-tax contributions is necessary, the plan administrator will notify affected employees.
- Pre-tax contributions to a DDCFSa are reported by Discover on your Form W-2, Box 10—Dependent Care Benefits.

Health Care Flexible Spending Account (HCFSA)

Eligible health care expenses (see the “Eligible Health Care Expenses” section) incurred by you or your eligible dependents may be reimbursed from the HCFSA. Medical expenses are incurred when the services are provided, not when billed or paid.

Definition of Eligible Dependents

The definition of eligible dependents for purposes of the HCFSA differs from the definition used for other Discover health plans. You may request reimbursement from your HCFSA for expenses incurred by:

- You
- Your spouse, as determined under federal tax law
- Your dependent children, as determined under federal tax law, who have not attained age 27, and
- Any individual you can claim as a dependent for federal income tax purposes, regardless of whether they meet the eligibility requirements of other Discover group health plans

Notes:

- Under IRS regulations the HCFSA program may not recognize civil union partners, domestic partners, or children of civil union partners and domestic partners as eligible dependents unless they meet the criteria listed above and the relationship is not in violation of local law.
- Your dependents’ eligible expenses can be reimbursed through the HCFSA, even if they are not enrolled as dependents under any of Discover’s health plans, provided that you can claim such persons as dependents on your federal tax form.

Eligible Health Care Expenses

In order to be eligible, the expenses must be:

- Of a type that would be tax deductible, and
- Incurred by December 31 of the current year, and
- Not reimbursable under any group health plan

Once you receive a reimbursement from the HCFSA or limited purpose HCFSA, that expense cannot be claimed as a deduction on your personal income tax return.

Some examples of out-of-pocket health care expenses, which qualify for reimbursement from the HCFSA and limited purpose HCFSA,¹ include:

- Medical, dental or vision program deductibles, coinsurance amounts and copayments
- Routine physician office visits—to the extent not covered by your medical program
- Annual physical examinations—to the extent not covered by your medical program
- Vision care expenses, including eye exams, prescription eyeglasses, contact lenses and contact lens solution—to the extent not covered by your vision program
- Hearing care expenses—to the extent not covered by your medical program
- Amounts determined to be above reasonable and customary (R&C) limits under your medical and dental programs
- Certain prescribed medical supplies and equipment—to the extent not covered by the medical program (insulin and diabetic supplies, bandages, braces, supports, first-aid supplies and contact lens solutions are eligible medical supplies)
- Orthodontic expenses—to the extent not covered by your dental program

¹You must be enrolled in the HSA plan to contribute to a limited purpose FSA. You can reimburse yourself for eligible dental and vision expenses, and eligible medical and prescription drug expenses incurred after you meet the HSA plan deductible.

- The difference between a hospital's semiprivate and private room charge
- Smoking cessation programs and drugs prescribed for smoking cessation—to the extent not covered by any other program
- Weight loss programs due to the diagnosis of a disease such as hypertension or obesity
- Expenses incurred for transportation primarily for and essential to medical care (out-of-pocket expenses, such as cost of gas or oil when driving your car, parking, tolls, bus or train tickets)

Ineligible Health Care Expenses

The following are some expenses that are not eligible for reimbursement:

- Joint counseling (for example, marriage or family counseling)
- Insurance premiums for any health plan
- Over-the-counter products not used to alleviate or treat personal injury or sickness but are used for general good health (for example, vitamins or dietary supplements or over-the-counter medications) without a doctor's prescription
- Food purchased through weight loss programs
- Expenses for custodial care in a nursing home or other long-term care
- Cosmetic surgery or cosmetic treatments such as teeth whitening (unless to correct a congenital deformity or to correct an injury from an accident)
- Medical and prescription drug expenses incurred before you meet the HSA plan deductible (if you are a participant in the HSA plan and elect a limited purpose FSA)

To determine if an expense you expect to incur is eligible for reimbursement, consult IRS Publication 502 on [irs.gov](https://www.irs.gov).

Requesting Payment of HCFSAs Benefits

The full amount that you elect to contribute to your HCFA is available at the beginning of the year. You may receive funds from your account as soon as you or an eligible dependent has an eligible expense, regardless of how much you have contributed toward your account as of the date you submit your request for reimbursement. If you increase your contribution amount during the plan year due to a qualified life event, only expenses incurred on or after the qualified life event date are eligible for reimbursement from the additional amount.

FSA claims are processed daily and checks are generally mailed within three business days. Expenses that are covered by a group health plan must first be submitted to the group health insurance plan for consideration.

In general, you may receive reimbursement from your HCFA two ways:

1) Through Click to Pay or Auto Pay.

Eligible out-of-pocket expenses incurred through the medical, dental, prescription and vision programs may be automatically forwarded to ConnectYourCare for reimbursement from your HCFA. You can choose to click to pay yourself and you will not need to submit an FSA claim form, or you can choose to switch to auto pay. Auto pay means that any time an expense is sent to ConnectYourCare from a medical, dental, prescription, or vision expense, you would automatically be reimbursed. Expenses incurred through the regional medical plans cannot be automatically reimbursed.

Only eligible out-of-pocket expenses covered by a group health plan will be forwarded for automatic reimbursement. Expenses which are not covered by a group health plan, such as over-the-counter medications and denied expenses, will not automatically be submitted to your HCFA for payment. You must submit a claim form as described on the following page.

You may contact ConnectYourCare at any time to turn the auto pay feature on or off; changes are not limited to the annual enrollment period or when you have a qualified life event.

Allow one to two weeks from the date of service for claims to be forwarded to ConnectYourCare for automatic reimbursement.

2) By submitting a claim.

You may submit claims for your unreimbursed health care expenses by completing the FSA claim process on the ConnectYourCare website, and attaching itemized bills, receipts and/or the Explanation of Benefits (EOB) from your health plan administrator as proof of unreimbursed eligible expenses. To be reimbursed for eligible over-the-counter medications, you must include with your claim an itemized receipt, which shows the specific name of the medication and the date of purchase. FSA claims can be submitted on **connectyourcare.com**.

If you wish to receive reimbursement for expenses not covered or denied by a group health plan, you will need to complete an FSA claim. If you are unsure if an expense is covered by your health plan administrator, contact your health plan's member services department.

You have until March 31 of the following calendar year to submit claims for reimbursement for expenses incurred by December 31 of the current year. You will only receive reimbursement for claims incurred while you were a participant in the HCFSa.

If you terminate employment or otherwise become ineligible to participate in the HCFSa due to an employment status change prior to December 31 (excluding transfer to an international status), you may only submit claims for reimbursement incurred through the end of the month of your termination, unless you elect to continue participation through COBRA (see the "Continuation Coverage Rights Under COBRA" section). Any amount in your account that is not reimbursed to you for eligible expenses incurred by December 31 will be forfeited.

Dependent Day Care Flexible Spending Account (DDCFSA)

Eligible dependent day care expenses are defined as costs incurred for the care of an eligible dependent that enables you, or if you are married, you and your spouse, to work or attend school as a full-time student or if your spouse is physically or mentally incapable of self-care. The only expenses eligible for reimbursement are those incurred for the primary purpose of assuring the well-being and protection of your eligible dependent.

Eligible expenses include, but are not limited to, the cost of a babysitter (for work or education-related expenses), day care center or home care center, as well as nursery school and day camp programs. Weekend or "evening-out" baby-sitting expenses, kindergarten expenses and overnight camp expenses are ineligible. Expenses incurred by married employees with spouses who are not working, not full-time students or not physically or mentally capable of self-care are also ineligible.

Health care expenses for your dependents are not payable under the DDCFSA, nor are expenses for food or clothing.

Definition of Eligible Dependents

For purposes of the DDCFSA, an eligible dependent is any "qualifying individual" determined in accordance with Section 21 of the Internal Revenue Code, including:

- A "qualifying child" as defined in Section 152 of the Internal Revenue Code who has not attained age 13. A qualifying child is your own child (including your son, daughter, stepson, stepdaughter, eligible foster child, adopted child or child placed for adoption) or your brother, sister, stepbrother, stepsister, half-brother, half-sister (or any of their descendants) who lives with you for more than one-half of the year and who has not provided over one-half of his or her own support.
- A person who is physically or mentally incapable of self-care, such as a disabled child or an elderly dependent parent who lives with you for more than one-half of the year and either was your dependent or would have been your dependent except that he or she

1. has gross income for the year that is less than the exemption amount (\$3,950 for 2014),
 2. he or she filed a joint return, or
 3. you, or your spouse, if filing jointly, could be claimed as a dependent on someone else's tax return.
- Your spouse who is mentally or physically incapable of self-care and who lives with you for more than one-half of the year.

In addition, if you are divorced or legally separated, you may cover a child whom you cannot claim as a dependent provided that:

- The child is under 13 or is physically or mentally incapable of self-care;
- The child received over half of his or her support during the calendar year from one or both parents who are divorced or legally separated under a decree of divorce or separate maintenance, are separated under a written separation agreement, or lived apart at all times during the last 6 months of the calendar year;
- The child was in the custody of one or both parents for more than half the year, and
- You were the child's custodial parent, meaning the parent with whom the child lived for the greater number of nights. If the child was with each parent for an equal number of nights, the custodial parent is the parent with the higher adjusted gross income. The noncustodial parent cannot treat the child as a qualifying person even if that parent is entitled to claim the child as a dependent under the special rules for a child of divorced or separated parents. For additional details of the federal tax rules, see IRS Publications 501 and 503.

Note: IRS regulations do not recognize civil union partners, domestic partners and children of civil union partners or domestic partners as eligible dependents unless they meet the criteria listed above and the relationship is not in violation of local law. You are responsible for determining whether an individual is your dependent under applicable tax law.

Your dependents' eligible expenses can be reimbursed through the HCFSA, even if they are not enrolled as dependents under any of Discover's health plans, provided that you can claim such persons as dependents on your federal tax form.

Eligible Dependent Day Care Expenses

You may submit a request for reimbursement from the DDCFSA for expenses incurred in a plan year that are eligible employment-related expenses and do not exceed earned income limitations to the extent you have a balance in the DDCFSA. Expenses eligible for reimbursement from a DDCFSA include:

- Payments made for services provided in your home, as long as these services are not provided by someone you also claim as a dependent or by your children who will be under age 19 at the end of the calendar year. Although these services may involve household maintenance, they must be attributable in part to the care of the eligible dependent.
- Payments made for day care services outside your home for a dependent child under age 13 or for other dependents who spend at least eight hours a day in your home.
- Payments made to a qualified day care center providing care for at least six people on a regular basis that requires a fee for care and that is in compliance with all applicable state and local laws.

Reimbursements from the DDCFSA may not exceed the applicable earned income limitation. If you are not married at the end of the plan year, the limit is your earned income, including your total wages, salary and other employee or self-employed compensation. If you are married at the end of the plan year, the limit is the lesser of your earned income or that of your spouse.

Consult your tax advisor or view IRS Publication 503 (available at [irs.gov](https://www.irs.gov)) to see if a particular type of expense is eligible for reimbursement.

The Dependent Care Tax Credit versus the DDCFSA

The IRS permits eligible taxpayers to take a tax credit equal to a percentage of eligible dependent day care expenses or fund eligible dependent day care expenses through an FSA. For employees with two or more eligible dependents, the Dependent Care Tax Credit (\$6,000) is greater than the amount you may pay from your DDCFSA (\$5,000). Therefore, you may be able to claim a tax credit for a percentage of your expenses above your DDCFSA election. Alternatively, the tax credit may be more valuable than the DDCFSA, depending on your income level. The amount of your contribution to a DDCFSA will directly offset (on a dollar-for-dollar basis) the amount of qualified expenses to be considered when determining the tax credit. You may wish to consult with your tax advisor or view IRS Publication 503 to determine which is most tax advantageous for you—the tax credit, the DDCFSA or a combination of both.

Your W-2 Form

The amount of your annual DDCFSA contribution will be shown in Box 10 of your W-2 Form. If this amount exceeds \$5,000, the amount over \$5,000 is taxable income and will also be included in Box 1 of your W-2 Form.

If you're elected to participate in a prior employer's DDCFSA and the combination exceeds \$5,000 in a given calendar year, consult with your tax advisor on how to report the additional taxable income and your dependent day care expenses.

Requesting Payment of DDCFSA Benefits

Once you start accumulating contributions credited to a DDCFSA, you may request reimbursement from your account for qualified dependent day care expenses.

Dependent day care reimbursements will be limited to amounts credited to your account (for example, your year-to-date contributions minus reimbursements) at the time your request for reimbursement is processed.

To obtain reimbursement, you must file a claim online and provide a copy of a paid receipt as proof of payment of your day care expenses and attach them to your FSA claim form. You also must include the Tax Identification Number (TIN) of the day care provider. No request for reimbursement will be paid without a TIN. If the provider is a tax-exempt organization, indicate this on your claim form. Forward the completed claim form to ConnectYourCare for reimbursement. Always keep copies of your claim forms and supporting documentation for your files.

You currently may submit requests for reimbursement for expenses incurred during the calendar year until March 31 of the following year. DDCFSA claims are processed daily and checks are generally mailed within three business days.

Account Balances

All contributions during any calendar year to either account must be applied to covered expenses incurred by December 31 of the current year. Eligible expenses will be paid to the extent there remains an FSA balance.

Contributions to the HCFSAs and DDCFSAs may be applied to eligible claims incurred through the end of the calendar year in which you cease coverage. Expenses are treated as incurred at the time the services to which the expenses are related are provided.

Requests for reimbursement must be submitted during the calendar year or by March 31 of the following year. All eligible health care expenses will be paid from your HCFSAs and eligible dependent day care expenses from your DDCFSAs. Funds cannot be transferred between your HCFSAs and DDCFSAs.

If there is any money remaining in your DDCFSA that is not used for eligible expenses incurred by December 31 of the current calendar year, federal tax law requires that money to be forfeited. If there is any money remaining in your HCFSAs up to \$500 it will automatically roll over into new plan year's account. You can view your account balance online at connectyourcare.com.

Note: Expenses incurred prior to your hire date or enrollment in the plan may not be submitted for reimbursement. Additionally, if you increase your FSA contribution amount during the plan year due to a Qualified Life Event (QLE), only FSA expenses incurred on or after the QLE are eligible for reimbursement from the additional amount.

Plan Termination

Coverage under the FSA program will terminate at the earliest of:

- The end of the calendar year (unless you re-enroll during the annual enrollment period)
- The date you cease making contributions
- The date your FSA balance has been completely distributed before the end of the calendar year (although your contributions continue)
- The end of the month you terminate employment or become ineligible for benefits, whichever is earlier, (although you may be eligible for COBRA continuation for the HCFSAs see “Continuation of Coverage Rights” under COBRA section for more information)
- The date the plan, or FSA program terminates

LIFE AND ACCIDENT INSURANCE

The Discover term life insurance, Accidental Death and Dismemberment (AD&D) insurance and Business Travel Accident (BTA), (collectively, the Life and Accident Program) provide valuable financial protection for you and your family. Life insurance coverage is summarized in the Minnesota Life insurance certificates, which is a supplement to this SPD and can be found on myHR.

Minnesota Life Insurance Company is the insurance carrier for the term life insurance program, and makes all determinations on when benefits are payable. For purposes of determining your amount of life insurance, HWEE is used. HWEE is rounded up to the next higher \$1,000. For example, \$34,445 would be rounded to \$35,000.

Life Insurance Program

Basic Coverage

Discover provides you with basic term life insurance coverage of one times your HWEE, up to \$500,000, for yourself, at no cost to you. Under IRS rules, the value of your basic term life insurance over \$50,000 is considered taxable income to you. This taxable income will be reflected on your paycheck and W-2 Form.

Supplemental Coverage

COVERAGE FOR YOURSELF.

You may elect to purchase coverage for yourself at one of the coverage options:

\$50,000	\$250,000	\$750,000	\$2,000,000
\$75,000	\$300,000	\$1,000,000	\$2,500,000
\$100,000	\$400,000	\$1,250,000	\$3,000,000
\$150,000	\$500,000	\$1,500,000	
\$200,000	\$600,000	\$1,750,000	

The options are also available on www.mydiscoverbenefits.com or the myHR website, subject to a maximum of eight times your Health and Welfare Eligible Earnings (HWEE), or \$3 million, whichever is less. Rates are based on your age as of January 1. Any supplemental life insurance coverage you elect for yourself is in addition to the basic term life insurance coverage provided by Discover.

COVERAGE FOR YOUR SPOUSE OR DOMESTIC PARTNER.

You may elect to purchase coverage for your spouse or domestic partner at one of the coverage options:

\$10,000	\$70,000
\$20,000	\$80,000
\$30,000	\$90,000
\$40,000	\$100,000
\$50,000	\$150,000
\$60,000	\$200,000

The options are also available on www.mydiscoverbenefits.com or the myHR website. Rates are based on your spouse's age as of January 1. The amount of coverage you elect for your spouse or domestic partner cannot exceed the supplemental coverage you elected for yourself and is limited to \$200,000. To ensure that premiums are accurate, you must provide the date of birth of your spouse or domestic partner.

COVERAGE FOR YOUR ELIGIBLE DEPENDENT CHILDREN.

You may elect to purchase \$5,000, \$10,000 or \$20,000 of coverage for each of your eligible dependent children, who are a live birth to age 26, regardless of marital status, eligibility for other coverage, or financially dependent on the parent. Employee's first eligible child has automatic coverage of \$10,000 within 31 days of birth.

EVIDENCE OF INSURABILITY (EOI) REQUIREMENTS

You and/or your spouse or domestic partner will be required to provide to Minnesota Life, medical evidence of good health, called Evidence of Insurability or EOI, in the following situations:

- You elect a coverage level in excess of \$1million for yourself (if available) or \$30,000 for your spouse or domestic partner
- You elect to increase your or your spouse's or domestic partner's coverage by more than one level during a period of annual enrollment, or
- At any time, if you previously waived coverage

WHEN IS EOI REQUIRED?			
COVERAGE LEVEL			
EVENT	YOU	SPOUSE/DOMESTIC PARTNER	CHILDREN/ ELIGIBLE DEPENDENTS
NEW HIRE OR NEWLY BENEFITS-ELIGIBLE (WITHIN 31 DAYS)	If employee elects over \$1 million (if available)	If electing over \$30,000	No EOI required
ANNUAL ENROLLMENT OR QUALIFIED LIFE EVENT	If previously eligible, but enrolling for the first time (any amount). If a qualified life event can enroll in the \$50,000 level with no EOI	If previously eligible but enrolling for the first time (any amount).	No EOI required
	If increasing more than one level or increase results in a supplemental insurance amount of over \$1 million	If increasing more than one level and if increase results in a coverage amount over \$30,000	
	If previously declined, any insurance amount due to failure to provide satisfactory evidence of insurability		

If EOI is required, when electing supplemental life insurance coverage for yourself, you must complete an online EOI when you make your coverage election. You will know immediately if the additional coverage you selected is approved or if you will need to provide more information to Minnesota Life.

If you are required to provide additional information or if you make your elections through a myHR Service Center Representative, myHR will mail you an EOI form with your confirmation statement. You must complete the form and return it directly to Minnesota Life within 31 days of the date printed on your confirmation statement.

Elections requiring Minnesota Life's approval will be effective the date the EOI is approved. (Coverage elected during annual enrollment will become effective the later of January 1 or the date the EOI is approved.) Until Minnesota Life approves the EOI, you or your spouse or domestic partner will be covered by, and you will pay for, the highest coverage level allowed without EOI. It is your responsibility to follow up with Minnesota Life regarding the status of any EOI. All increases are subject to the "active at work" rule (see the "Active at Work Rule" section below).

There is a two-year contestability clause in the event of death occurring within two years of EOI approval. Minnesota Life reserves the right to withhold benefits if Minnesota Life determines that misrepresentation of EOI has occurred.

"Active at Work" Rule

If you are ill or injured and away from work on the day your coverage (or any increase in coverage) would become effective, the effective date of coverage (or increase) and any increase in premium will be deferred (for yourself and eligible dependents) to the date you return to work for one full day. As an exception, coverage provided under the 31-day child automatic coverage from live birth provision applicable to an employee's first eligible newborn child is not subject to the "active at work" rule.

Accelerated Death Benefit

If you or your dependents have a life expectancy of 24 months or less, you can request an accelerated death benefit from the term life insurance plans. To qualify for an accelerated benefit, you or your covered dependent must:

- Be insured for at least \$10,000;
- Have not assigned ownership rights under the coverage;
- Not have an irrevocable beneficiary; and
- Be terminally ill (life expectancy of 24 months or less).

If you qualify, you may choose a full or a partial accelerated benefit. A partial benefit can only be requested if the remaining amount after the early payout is at least \$25,000. If a partial benefit is chosen, coverage will remain in force and the amount remaining will be the full amount prior to the early payout minus the amount that was accelerated. If a full benefit is paid, the coverage will end. If your employee life coverage ends due to taking a full benefit, then any coverage on your dependents will also end at that time, though they will have the right to convert to an individual policy as described in the conversion section.

An accelerated benefit will be made available on a voluntary basis only. An accelerated benefit under this supplement is not intended to cause an involuntary reduction of the death benefit ultimately payable to the named beneficiary. Therefore, payment of the death benefit cannot be accelerated under this supplement if the insured:

- Is required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; or
- Is required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement.

The maximum amount of coverage that can be accelerated is \$1 million.

Life Insurance Program Exclusions/Change in Coverage

There are no exclusions (causes of death for which a benefit would not be paid) under the life insurance program.

In certain circumstances you may not be eligible for life insurance coverage even if you have paid premiums for such coverage. If coverage is provided in error and it is later determined that you or your dependents were not eligible for life insurance coverage due to failure to obtain EOI, meet the active at work rule or for some other reason (as determined by the plan), you shall receive a full refund of any insurance premiums you have paid in error. You shall have no right to a claim for life insurance from Minnesota Life, the plan or Discover.

Accident Insurance Programs

Discover offers the following accident insurance programs to provide financial protection if, within 365 days of an accident, you or a covered dependent die or suffer dismemberment, loss of sight, speech or hearing, coma, or suffer paralysis as a result of the accident:

- Basic AD&D insurance program
- Supplemental AD&D insurance program
- Business Travel Accident (BTA) insurance program

Covered accidents include all accidents while coverage is in effect, other than those listed in the Accident Program Exclusions section.

The accident programs are underwritten by Life Insurance Company of North America (LINA), an affiliate of CIGNA.

Basic AD&D Insurance Coverage

Discover provides you with coverage of one times your HWEE, up to \$500,000, for yourself, known as your principal sum, at no cost to you. For purposes of determining your basic AD&D, HWEE is rounded up to the next higher \$1,000. For example, \$34,445 would be rounded to \$35,000.

Supplemental AD&D Insurance Coverage

- **Coverage for yourself.** You may elect to purchase additional coverage for yourself only (over and above basic AD&D coverage) for \$50,000 or in multiples of \$100,000 subject to a maximum of \$1 million. The coverage amount is known as your principal sum.
- **Coverage for your spouse or domestic partner.** If you elect to cover yourself plus spouse or domestic partner, your spouse or domestic partner is insured for 100% of your elected principal sum to a maximum of \$700,000.
- **Coverage for yourself plus eligible dependent children.** If you elect to cover yourself plus eligible dependent children, each child is insured for 25% of your elected principal sum to a maximum of \$50,000.
- **Coverage for yourself plus family.** If you elect to cover yourself plus family, your spouse or domestic partner is insured for 75% of your elected principal sum to a maximum of \$700,000, known as his/her principal sum, and each child is insured for 25% of your elected principal sum, known as the child's principal sum.

If an insured dependent child suffers a covered dismemberment, loss of sight, speech, hearing, coma or paralysis, the benefit will be doubled, to a maximum of \$250,000. If your child subsequently dies within 365 days of the covered accident, only the loss of life benefit will be paid.

Business Travel Accident (BTA) Insurance Coverage

Discover provides BTA insurance coverage at no cost to you. BTA coverage is provided while you are traveling on company business away from the premises of your regular assignment. Your coverage begins at the actual start of the business trip—the moment you leave your home or workplace, whichever occurs last. Your coverage ends the moment you return to your workplace or home, whichever occurs first.

- **Coverage for yourself.** The amount of your BTA coverage is five times your HWEE, subject to a minimum amount of \$250,000 and a maximum amount of \$3 million. This amount is known as your principal sum.
- **Coverage for your spouse or domestic partner and eligible dependent children.** Your spouse or domestic partner and dependent children are covered for losses sustained while traveling with or in conjunction with your business travel and/or in connection with your relocation, provided these trips are at Discover's expense and direction:
 - Your spouse or domestic partner's principal sum is 50% of your principal sum
 - Each dependent child's principal sum is 20% of your principal sum

A domestic partner is considered an eligible dependent, provided he or she meets the criteria listed in the Domestic Partnership Eligibility section prior to the business trip.

Aggregate Limit. If one or more covered persons (employee, covered spouse or domestic partner or covered dependent children) are traveling on a trip authorized by Discover and suffer a covered loss as a result of the same aircraft accident, the maximum that the BTA insurance program will pay for all accidental death losses is \$20 million per aircraft accident.

If total accidental death losses exceed \$20 million, the accidental death benefits paid on each covered person will be reduced proportionately so as not to exceed the \$20 million program limit.

If one or more covered persons suffer a covered loss as a result of the same terrorist act on the premises of Discover, the maximum the BTA insurance program will pay for all covered losses is \$20 million per incident. If total losses exceed \$20 million, the benefits paid on each covered person will be reduced proportionately so as not to exceed the \$20 million program limit. LINA determines, in its sole discretion, whether an incident is a terrorist act.

Payment of Benefits

Full benefits under the accident programs are paid for certain losses, including death, dismemberment or paralysis. Partial benefits are paid for other losses. If, within 365 days of the accident, you or your eligible dependents suffer a covered loss listed on the next page, the payment shown will be made:

COVERED LOSS	PAYMENT ¹
Loss of life	The principal sum
Loss of two or more hands or feet	The principal sum
Loss of sight in both eyes	The principal sum
Loss of one hand or foot and sight in one eye	The principal sum
Loss of speech and hearing (in both ears)	The principal sum
Loss of one hand or foot	1/2 the principal sum
Loss of sight in one eye	1/2 the principal sum
Loss of speech	1/2 the principal sum
Loss of hearing (in both ears)	1/2 the principal sum
Loss of thumb and index finger of the same hand	1/4 the principal sum
Loss of all four fingers of the same hand	1/4 the principal sum
Loss of all the toes of the same foot	1/4 the principal sum
Quadriplegia	The principal sum
Paraplegia	The principal sum
Hemiplegia	The principal sum
Uniplegia	1/2 the principal sum

¹ Unless otherwise specified, only one benefit—the highest—will be paid if you or your dependents suffer more than one loss resulting from a single accident. The principal sum is the amount defined in the Supplemental AD&D Coverage and Business Travel Accident (BTA) Insurance Coverage sections.

Definition of Loss

- Loss of a hand or foot means complete severance through or above the wrist or ankle joint
- Loss of sight means the total, permanent loss of sight in one eye. The loss of sight must be irrecoverable by natural, surgical or artificial means
- Loss of speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means
- Loss of hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means
- Loss of a thumb and index finger of the same hand or loss of four fingers of the same hand means complete severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand)
- Loss of toes means complete severance through the metatarsophalangeal joint
- Paralysis or paralyzed means total loss of use (a physician must determine the loss of use to be complete and not reversible at the time the claim is submitted)
- Quadriplegia means total paralysis of the upper and lower limbs
- Hemiplegia means total paralysis of the upper and lower limbs of one side of the body

- Paraplegia means total paralysis of both upper or lower limbs
- Uniplegia means total paralysis of one upper or one lower limb
- Severance means complete separation and dismemberment of the part from the body

Additional Coverage Under the Basic and Supplemental AD&D Insurance Programs

Permanent Total Disability Benefit (For Employees Only)

If you become totally disabled (as defined below), within 365 days after a covered accident and remain totally permanently disabled (as defined below) for at least 12 months, you will be paid your principal sum, less any amount paid for accidental dismemberment.

Totally disabled means your inability to do any type of work for which you may become qualified by reason of education, training or experience.

Totally permanently disabled means you are totally disabled and expected to remain so, as certified by a physician, for the rest of your life.

Coma Benefit

If, as a result of a covered accident, an insured employee or covered dependent becomes comatose within 31 days of the accident and remains comatose beyond a waiting period of 31 days, 1% of the principal sum benefit is payable on a monthly basis for a maximum of 11 consecutive months. Benefit payments will cease on the earliest of:

- The end of the month in which death occurs,
- The end of the 11th month for which this benefit is payable, or
- The end of the month in which there is recovery from the coma

If you or a covered dependent dies from any cause as a result of the covered accident while this coma benefit is payable or remains comatose after this coma benefit is payable for 11 straight months, a lump-sum benefit will be paid equal to the principal sum, reduced by the amount (if any), already paid for the loss caused by the covered accident.

If coma benefits are payable, benefits will not be payable under the Permanent Total Disability (PTD) benefit in this program for the same covered accident.

If an insured person is receiving a coma benefit, and recovers from the coma within the 11-month period, the coma benefit will cease. The insured may be eligible for the PTD benefit (less any amount paid under the coma benefit) provided the insured is deemed to be PTD, within 365 days from the date of the accident.

If the insured person has received 11 months of the coma benefit and also received the 100% lump-sum payment after the 11-month period, they will not be eligible for the PTD benefit even if they recover after they have received 111% of their principal sum (1% of principal sum each month for 11 months and then 100% of principal sum).

Seatbelt and Airbag Benefit

The Basic AD&D program will pay an additional accidental death benefit of 10% of the principal sum to a maximum of \$5,000 for the seatbelt benefit and 20% of the principal sum to a maximum of \$10,000 for the airbag benefit. If you or your covered dependent suffers loss of life as a result of a covered accident which occurs while you or your covered dependent are driving or riding in a private passenger car, if:

- The car is equipped with seat belts,
- The seat belt was in actual use and properly fastened at the time of the accident, and
- The position of the seat belt is certified in the official report of the accident by the investigating officer

A copy of the police report must be submitted with the claim. If such certification is not available or it is unclear whether the covered person was properly wearing a seat belt, the plan will pay a fixed benefit of \$1,000 to the named beneficiary.

In the case of a child, seat belt means a child restraint, as required by the state law and approved by the National Highway Traffic and Safety Administration, properly secured and being used as recommended by its manufacturer for children of like age and weight at the time of the covered accident.

Child Care Center Benefit (For Employees Only)

If your death is the result of a covered accident, a day care benefit will be paid for each eligible child who is enrolled in a licensed day care child facility within 365 days from the date of the accidental death. The day care benefit will be 10% up to \$5,000 per year under the basic AD&D insurance program and 10% of the amount of your coverage up to a maximum of \$10,000 per year under the supplemental AD&D insurance program. The day care benefit will be paid for each school year for as long as your child remains enrolled in a legal childcare center up to five years or until age 13, whichever occurs first.

Spouse Retraining Benefit for Spouse or Domestic Partner and Education Benefit for Children (For Employees Only)

For spouse or domestic partner. In the event of your death, due to and within 365 days of an injury resulting from a covered accident, your spouse or domestic partner may receive a retraining benefit equal to the actual cost of tuition up to a lifetime maximum of \$5,000 under the basic AD&D insurance program and up to a lifetime maximum of \$10,000 under the supplemental AD&D insurance program.

To be eligible to receive this benefit, your spouse or domestic partner must:

- Enroll in an occupational training program for the purpose of obtaining an independent source of income, and
- Incur the cost for occupational training within three years following the date of your death

Occupational training means any occupational or educational training needed for employment.

The expense incurred means the actual tuition charges, exclusive of room and board, and actual cost of materials needed for the occupational training program.

For dependent children. In the event of your death, due to and within 365 days of a covered accident, your eligible children may receive an educational benefit. The basic AD&D insurance benefit will be \$5,000 per child per year, and the supplemental AD&D insurance benefit will equal the lesser of 10% of your principal sum or \$25,000 per child per year. The benefit will be paid annually for a maximum of four consecutive annual payments if he or she remains enrolled as a full-time student.

To be eligible to receive this benefit, your child must be a full-time student in:

- A grade higher than the 12th grade level, or
- The 12th grade level and subsequently enrolled as a full-time student in a higher grade within 365 days of your death

If, at the time of your death, you do not have any covered dependents eligible for the education benefit, the insurance company will pay your beneficiary an additional benefit of \$1,000.

In-Hospital Income Benefit

Under the basic AD&D insurance program, if you, or under the supplemental AD&D insurance program, if you or your covered dependents are hospitalized for 24 hours or more within 90 days of a covered accident, the plan will pay, after a seven-day waiting period, a flat \$1,000 per month for the duration you or covered dependent is in the hospital for a maximum of 24 months.

Rehabilitation Benefit (For Employees Only)

The covered person must require rehabilitation within two years after the date of the covered loss. If you suffer an injury that results in any covered loss other than loss of life, you will receive, in addition to the loss benefits described in the “Payment of Benefits and Claims and Appeals” section, a rehabilitation benefit equal to the lesser of:

- 5% of the principal amount to a maximum of \$1,000, or
- \$1,000

Rehabilitative training means any training which is required due to your injury to prepare you to return to your or any other occupation which meets generally accepted standards of medical practice and are performed under the care, supervision or order of a physician.

The expense (the actual cost of the training and the materials needed for the training) must be incurred within 24 months of the date of the accident. The covered loss must be due to a covered injury and must occur within 365 days of the accident that caused the injury.

Common Disaster Benefit (Supplemental AD&D Insurance Program Only)

If you elect coverage for yourself plus family, and you and your spouse or domestic partner die within one year as the result of injury received in the same accident or in separate accidents that occur within 24 hours of each other, a principal sum is payable under the program for each death. The principal sum applicable to your spouse or domestic partner will be increased to 100% of your principal sum, subject to a \$1 million maximum.

Additional Coverage Under the BTA Insurance Program

Relocation

If Discover changes your assigned place of employment to another location and reimburses travel expenses due to that relocation, you and your eligible dependents are covered for any losses, which may occur during travel due to that relocation.

Your relocation coverage begins on the later of:

- Your departure from your place of residence, or
- Your departure from Discover premises of the prior location of employment

Relocation coverage for your spouse or domestic partner and eligible dependent children begins at departure from their place of residence.

Relocation coverage ends on your first day of employment at your new location or 10 days from the date the coverage began.

Personal Deviations Coverage

The BTA insurance program extends coverage to include losses, which occurred while you engage in personal deviations while traveling on business for Discover. Personal deviations mean any activity that is not reasonably related to or incidental to Discover business, including approved home visits for expatriate employees.

Alternative Commuting

The BTA insurance program will pay benefits for a covered loss from an accident, which occurs while you are commuting directly between your home and Discover premises where you normally work, if:

- You use an alternate means of transportation for such commutation, and
- It is necessary to use such means of transportation due to discontinuance of service, strike or major breakdown of one or more public conveyance transportation systems which you regularly use in commuting

Coma Benefit

If, as a result of a covered accident, an insured employee or covered dependent becomes comatose within 31 days of the accident and remains comatose beyond a waiting period of 31 days, 1% of the principal sum benefit is payable on a monthly basis for a maximum of 11 consecutive months. Benefit payments will cease on the earliest of:

- The end of the month in which death occurs,
- The end of the 11th month for which this benefit is payable, or
- The end of the month in which there is recovery from the coma

If you or a covered dependent dies from any cause as a result of the covered accident while this coma benefit is payable or remains comatose after this coma benefit is payable for 11 straight months, a lump-sum benefit will be paid equal to the principal sum, reduced by the amount (if any), already paid for the loss caused by the covered accident.

If coma benefits are payable, benefits will not be payable under the Permanent Total Disability (PTD) benefit in this program for the same covered accident.

If an insured person is receiving a coma benefit, and recovers from the coma within the 11-month period, the coma benefit will cease. The insured may be eligible for the PTD benefit (less any amount paid under the coma benefit) provided the insured is deemed to PTD, within 365 days from the date of the accident.

If the insured person has received 11 months of the coma benefit and also received the 100% lump-sum payment after the 11-month period, he or she will not be eligible for the PTD benefit even if they recover after they have received 111% of their principal sum (1% of principal sum each month for 11 months and then 100% of principal sum).

Felonious Assault Coverage

The BTA insurance program provides coverage for covered losses sustained as the result of a felonious assault or from the commission or attempt to commit any of the following acts while on the property of Discover:

- Actual or attempted robbery or holdup;
- Actual or attempted kidnapping; or
- Any other types of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred.

Seat Belt Benefit

The BTA Insurance Program will pay an additional accidental death benefit of 20% of your or your eligible dependents' principal sum up to a maximum of \$25,000, if you or your eligible dependents suffer a loss of life as a result of a covered accident which occurs while you or your eligible dependents are driving or riding in a private passenger car, if:

- The car is equipped with seat belts,
- The seat belt was in actual use and properly fastened at the time of the accident, and
- The position of the seat belt is certified in the official report of the accident or by the investigating officer

A copy of the police report must be submitted with the claim. If such certification is not available and it is unclear whether the covered person was properly wearing a seat belt, the plan will pay a fixed benefit of \$1,000 to the named beneficiary.

In the case of a child, seat belt means a child restraint, as required by the state law and approved by the National Highway Traffic Safety Administration, properly secured and being used as recommended by its manufacturer for children of like age and weight at the time of the covered accident.

Accident Program Exclusions

No payment will be made for any loss if it results from or is caused or contributed by:

- Intentionally self-inflicted injury, suicide or any attempt thereat while sane or insane;
- Declared or undeclared war or act of war in the U.S., Afghanistan, Iran, Iraq, Israel and Pakistan;
- Flight in, boarding or alighting from an aircraft or any craft designed to fly above the earth's surface;
- Being flown by the covered person or in which the covered person is a member of the crew;
- Being used for any operation that requires a special permit from the FAA;
- Being used by any military authority, except an aircraft used by the Air Mobility Command or its foreign equivalent;
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection, or medical or surgical treatment thereof, except for any injury or infection which results from accidental involuntary or unintentional ingestion of a contaminated substance;
- Travel in any aircraft owned, leased or controlled by the policyholder, or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by the policyholder if the aircraft may be used as the policyholder wishes for more than 10 straight days, or more than 15 days in any year; or
- A covered accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered accidents that occur while engaged in reserve or National Guard training are not excluded until training extends beyond 31 days.

Note: These are accident-only policies. These programs do not pay benefits for losses caused by or resulting from illness, disease or bodily infirmity.

Designating a Beneficiary

You can designate a person, estate or trust as your beneficiary under coverage for yourself for the life and accident program. **You are automatically the beneficiary for spouse/domestic partner or child life insurance. Death benefits payable under the dependent coverage will be paid to you, if living, otherwise to your estate.**

To designate a beneficiary, go to the main menu on the myHR website, click on “Your Profile, Beneficiaries” and then click “Choose Beneficiaries.” Once you have entered all required information, click “Continue” and “Save and Continue.” Your beneficiary designations will take effect immediately if you successfully submit them online.

You can change beneficiaries for coverage for yourself at any time. Any requests to add or change a beneficiary must be made with myHR. A change will take effect immediately on the date it is successfully submitted online by you or by an authorized myHR Service Center Representative.

If you designate a trust as beneficiary for your coverage, you will need to meet the following requirements:

- The trust is a valid trust under state law (or would be but for the fact that there is no corpus)
- The trust is irrevocable or will, by its terms, become irrevocable upon your death
- The trust beneficiaries must be identifiable within the trust

The full amount of your life and accident insurance coverage is payable to your named beneficiaries. Benefits are normally paid in a lump sum. However, other payment methods may be available from the insurance carrier.

Life Insurance Program

If there is no proper beneficiary form on file with myHR or if your named beneficiary predeceases you, life insurance program benefits on your life will be paid in the following order of priority:

- Your surviving lawful spouse (does not include a domestic partner); otherwise
- Your surviving natural or legally adopted children equally; otherwise
- Your surviving parents, equally; otherwise
- Your surviving brothers and sisters, equally; otherwise
- Your estate

Assignment of Benefits

You may assign or transfer the ownership of your life insurance policy benefits to a trust or other third party. Any such assignment is irrevocable and will transfer all right, title, interest, and incidence of ownership, both present and future, in such benefits. Included are your rights to name a beneficiary or to convert coverage to an individual policy.

If you decide to assign your life insurance policy benefits, contact myHR to obtain the appropriate paperwork from the insurance carrier(s) necessary to execute the assignment of benefits.

There may be tax consequences to any assignment or transfer of ownership of life insurance policy benefits. Consult a tax advisor before you make a decision to assign policy benefits.

Note: Any spouse/domestic partner or children life insurance is assigned along with your coverage.

Basic and Supplemental Life Insurance Portability

If you no longer meet the eligibility requirements for coverage under the group policy due to termination of employment, moving to an ineligible class, or amendment to the group policy, you may elect to continue your employee term life insurance and the coverage of your dependents. To continue dependent coverage, you must continue your own voluntary coverage.

You must be under age 70 to continue coverage, otherwise lost under the portability provision. You are not eligible to continue coverage if you were not actively at work due to sickness or injury on the day before you terminate employment, become laid off, leave, or lose eligibility; or if the employer has canceled the group policy.

You may continue all or a portion of your supplemental Term Life with a minimum of \$10,000 and a maximum of previous amount not to exceed \$1 million (\$650,000 if 65 or older). You may continue all or a portion of your spouse term life insurance to a maximum of \$150,000 (\$97,500 if age 65 or older). All child coverage currently in force may be continued.

Upon an insured's attainment of age 65, the amount of insurance will reduce to 65% of the amount of insurance in force on the day prior to attainment of age 65. Coverage terminates upon attainment of age 70. In addition, in the case of a dependent child, coverage will also terminate when the child ceases to be eligible as defined under the terms of the group policy.

How to Port Coverage

In order to continue your coverage, Minnesota Life must receive a completed Portability Election Form within 60 days of the date the coverage would otherwise have terminated. Contact Minnesota Life at **866-293-6047** for a portability election form and additional information (including rates). All coverage is continued without proof of good health.

If You Terminate or Become Ineligible for Benefits

Your active basic and supplemental life insurance coverage will end on the day your employment ends, you lose eligibility or you stop making the required payments, whichever is earlier. In addition to the portability option referenced above, basic and supplemental life insurance coverage not eligible for portability may be converted to an individual life insurance policy. Conversion is also available when ported coverage ends. Evidence of insurability is not required for portability or conversion, but application must be made within 60 days of the date life insurance coverage terminates. If you die within the 60-day period in which you are eligible to apply for conversion or portability, and before an election is made to either port or convert coverage, your life insurance coverage will be considered to be in force.

If you leave Discover due to an involuntary termination without cause (for example, due to a reduction in force or facility closing), your and your spouse's or domestic partner's and covered dependent children's (if any) active basic and supplemental life insurance coverage may be eligible to be continued for a period of time following your termination date (at no cost to you) if you have:

- Been covered under the life insurance program for at least one year
- Not reached age 60 on the date your employment terminates (even if your spouse is over age 60), and
- Not converted your coverage to an individual policy

If you meet the eligibility criteria listed above, coverage will be continued, at no cost to you:

- For one month for each year that you have been covered under the life insurance program, not to exceed three months, and
- For the amount of life insurance in effect on the date your employment terminated.

Basic life insurance continues until the earlier of the date you stop receiving LTD benefits, the date you reach age 65 or your settlement effective date if you receive a lump-sum settlement from CIGNA. All other benefits generally cease at your date of termination from Discover. See the “Continuation of Coverage During Life Events” section for more details.

If you are receiving LTD benefits and are under age 65, you may continue your supplemental life insurance coverage by paying the same rates as active employees. This does not apply to dependent life insurance coverage. You will be billed monthly by myHR. Upon termination of your LTD benefits or attaining age 65, you may convert your supplemental life insurance to an individual policy.

Conversion

An insured may be eligible to convert basic and/or supplemental life insurance coverage to a new individual insurance policy if all or part of the insured’s life insurance terminates. To convert coverage the appropriate conversion application form must be submitted to Minnesota Life within 60 days of the loss of coverage. Rates may be significantly higher than active group life insurance rates.

Once an individual policy becomes effective, that policy will be in exchange for all benefits and privileges under the group contract.

Special Death Benefit Payment

Discover provides a special death benefit payment to employees and benefits-eligible dependents of a Discover employee in the event of the death of an employee or benefits-eligible dependent. This payment is separate from any life insurance benefit provided by Discover as described above. This benefit is available only to active Discover employees; it is not available to terminated employees.

For an employee death, Discover will pay the employee’s designated life insurance beneficiary(ies) a one-time payment equal to the greater of either one month in gross salary, or a one-time payment equal to \$2,000.

For the death of a benefits-eligible dependent of a Discover employee, Discover will make a payment to the employee in the amount of \$2,000 (which will be grossed up for taxes).

Accidental Programs

Basic and supplemental AD&D insurance and BTA insurance coverage for you and your dependents will terminate on the earliest of the following:

- The date your employment terminates for any reason
- The date you become ineligible for benefits due to an employment status change
- If you stop making the required contributions for this coverage (supplemental AD&D insurance coverage only)
- The date the program or accident program terminates

Dependent coverage will also cease when your dependents are no longer eligible (see the “Eligibility” section).

Conversion and portability policies are not available for accident program coverage.

If You Retire

Life insurance coverage for active employees terminates on the last day of the month in which you retire. Accident insurance coverage terminates on the day you retire.

The conversion privilege for the life insurance program described for terminated employees also applies to employees who retire, but applies only to the difference between your active life insurance amount and your retiree life insurance amount (if applicable). When you retire, you can port or convert the balance of your basic life insurance coverage in accordance with the portability and conversion provisions previously discussed. Refer to the Conversion and Portability subsections for more information.

Accident insurance (including BTA insurance) is not convertible or portable.

DISABILITY PROGRAM

The Discover disability program provides a regular income if you become disabled due to illness, injury or pregnancy and are unable to work.

- Short-Term Disability (STD) continues to pay you a percentage of your Basic Weekly Earnings (BWE) based on your years of service, for up to 25 weeks, if you are unable to work due to illness, injury or pregnancy
- Long-Term Disability (LTD) continues to pay part of your Health and Welfare Eligible Earnings (HWEE) (as defined in this SPD) after you have been disabled for 180 consecutive days, in accordance with the disability program

Short-Term Disability (STD) Benefits

Waiting Period

Non-exempt employees are eligible for STD benefits after six months of benefits-eligible employment with Discover and/or its participating subsidiaries, counting from the most recent hire date. This is called the STD waiting period. If you are a non-exempt employee in the waiting period upon the start of a disability you will not be eligible for STD benefits for that disability. You must have completed the waiting period by the first date of a disability in order to be eligible to receive STD benefits.

There is no waiting period for exempt employees.

If an exempt or non-exempt employee receives statutory state benefits, you may have to meet the waiting period for the applicable state benefit.

Definition of Disability

You are considered disabled if, based on medical information provided by your physician, the claims administrator determines that as a result of illness, injury or pregnancy, you are not working in any occupation and are:

- Unable to perform the essential functions of your regularly scheduled occupation, or
- Unable to perform any other job Discover offers you for which you are qualified

You will also be considered disabled under the plan and continue to receive STD benefits if you are performing job responsibilities as part of an alternative work duty assignment (see the “Alternative Work Duty” section).

STD Benefits

STD benefits may be paid after you have been determined to be disabled due to an injury, illness or pregnancy for longer than seven consecutive calendar days. You will be paid up to the maximum of 25 weeks retroactive to your first day of disability after the waiting period. If approved for STD, any Paid Time Off (PTO) days used to meet the waiting period will not be restored. You must comply with all applicable procedures (described in the “Payment of Benefits” section) to be eligible to receive benefit payments. STD benefits are generally paid through ordinary payroll, are taxable and subject to other applicable deductions.

Benefit Amount

STD provides you with a percentage of your basic weekly earnings (BWE; see definition below), based on your completed years of service, according to the following chart:

YEARS OF SERVICE	MAXIMUM WEEKS AT 100% BWE	MAXIMUM WEEKS AT 66% BWE
0-2	1	24
3-4	4	21
5-9	12	13
10-14	16	9
15+	25	0

- STD benefits are based on completed years of service as of the date of disability.
- Periods in which you receive payment for Paid Time Off (PTO) days will not be counted as part of the 25 weeks, but will be included when determining your 180-day elimination period before receiving LTD benefits. See the “Long-Term Disability” (LTD) section for details.
- Service is generally defined as the sum of your periods of employment with Discover or an affiliate, excluding any breaks in employment. The STD benefit amount is based on years of service as determined by adjusted benefits service date as of the start of disability. The STD benefit amount will not be adjusted for employees who cross into a new service anniversary during their STD leave.
- An example of STD benefit based on years of service would be, if you have 2 years and 3 months of service when you became disabled, you will receive STD for 1 week at 100% and the remainder will be at 66%.

Basic Weekly Earnings (BWE)

BWE is your gross weekly pay from Discover in effect prior to your date of disability. It includes your total income from Discover before taxes and deductions made for employee benefit plan contributions, for example, a 401(k) Plan, flexible spending accounts or Commuter Benefits Program (CBP). It does not include income received from commissions, bonuses, shift differential, overtime pay or any other extra compensation or income.

BWE for non-exempt employees is based on a standard workweek that, for flex part-time and regular part-time employees, is 35 hours per week and 25 hours per week, respectively. BWE for all full-time employees is 40 hours per week. BWE for an exempt employee who is not working full-time is based on his or her scheduled workweek.

Payroll deductions will continue from your STD benefits, as applicable in order to continue your benefits.

Offset for Other Disability Income

If you receive statutory disability benefits (for example, employees working in California, Hawaii, New Jersey, New York, Rhode Island or Puerto Rico) or similar benefits provided under any other Discover-provided plan, the amounts that you receive under those plans will reduce any amounts that you would otherwise receive under Discover’s STD coverage. If eligible, contact Leave Administration at myHR for information about your state-mandated STD coverage.

If you become eligible to receive STD benefit payments under any other group STD program, you will not be eligible for STD payments under Discover’s disability program.

Coordination of STD and State Disability Insurance Benefits

Effective September 1, 2013, if eligible for statutory disability benefits, Discover Leave Administration will calculate the approximate state disability pay from the applicable state at the initiation of the

leave in order to calculate the difference in STD benefit from Discover. You are responsible for filing your disability claim with the applicable state and providing a copy of the check stub to Discover Leave Administration. A delay in providing a copy will delay any applicable adjustment to your STD benefit.

Note: If your state disability income benefit is greater than Discover's STD benefit, then no STD benefit will be paid by Discover. Your state disability income benefit payment will be issued by the state and mailed directly to you.

Continuation of Other Health and Welfare, Retirement and Savings and Other Benefits

While you are employed by Discover and are receiving STD benefits, you will continue to participate in the following benefit plans if you were enrolled in them immediately prior to your disability (subject to your continued contributions where applicable):

- Medical, dental and vision programs
- Critical illness insurance
- Life insurance program (including both basic and supplemental coverage)
- Accidental death and dismemberment (AD&D) insurance program (including both basic and supplemental coverage)
- LTD program
- Flexible spending account (FSA) program
- Discover's 401(k) Plan
- Continued accrual of vesting service under the Discover Pension Plan (if eligible)
- MetLife group auto, home and pet insurance
- Legal assistance program

Business travel accident (BTA) insurance coverage will cease but automatically will resume when you return to work.

Commuter Benefits Program (CBP) contributions will also cease. Once you return from your leave, you must reenroll to participate in CBP.

Requesting Payment of STD Benefits

To request STD benefits, you must:

- First, contact your manager to report any absence greater than seven consecutive calendar days.
- Then, contact Leave Administration at myHR by calling 844-DFS-myHR (**844-337-6947**). Leave Administration will send you a medical disclosure authorization form. Complete, sign and send or fax the form to Leave Administration. This form allows Leave Administration to contact your physician to obtain needed medical information in order to make a determination of your request.

You and your physician will be required to provide information and/or complete certain forms to be submitted directly to Leave Administration.

Note: You must see your physician prior to the seventh consecutive calendar day following your last day worked in order to receive full benefits under the plan. Failure to receive prompt treatment from your physician may delay or reduce your benefits. Due to conflicting medical information, an employee may be required to undergo an independent medical exam. If the employee denies or refuses to undergo an independent medical exam, STD may be denied.

Leave Administration may not make a determination that you are entitled to STD benefits without your signed medical disclosure authorization form and the necessary information from your physician.

Leave Administration will verify certain information with your manager or HR representative, such as:

- Your last day worked, and
- Your job responsibilities

Leave Administration will verify certain information with your physician, such as:

- You are under the regular care of a physician
- The date of your disability
- The cause of your disability
- The extent of your disability, including any restrictions and limitations preventing you from performing your regular occupation
- The name and address of any hospital or institution where you received treatment, including all attending physicians

If the information required by Leave Administration is not received and a determination is not made within 30 calendar days from your first day absent, you will be placed on an unpaid leave. If your claim is subsequently approved, you will be paid STD benefits retroactively to your first day of approved disability. If Leave Administration does not approve your claim and you do not return to work, your employment may be terminated at Discover's discretion.

Leave Administration may request that you provide proof of continuing disability and that you are under the regular care of a physician who is qualified to treat the type of injury or illness in which your claim is made. This proof, provided at your expense, must be received as soon as possible (and no later than 15 calendar days after the request) to avoid an interruption in your benefits.

STD Benefits Duration

Benefits start after you have been disabled for more than seven consecutive calendar days and Leave Administration at myHR has approved your request for payment. Benefits will be paid retroactively to your first day of approved disability after the waiting period.

Once STD benefits are approved by Leave Administration, subject to the provisions detailed in the Termination of Coverage section, benefits will continue to the earliest of the:

- Date you are no longer disabled under the terms of the plan or you return to work
- End of the maximum period of payment (25 weeks)
- Date you fail to submit proof of continuing disability
- Date you qualify for LTD benefits, if eligible
- Date when you are able to return to work in a temporary alternative work duty assignment (see the Alternative Work Duty section) for which you are qualified because of your education, training or experience, but refuse the offer of such assignment by Discover
- Date you die

Payment of Benefits

Discover will make all payments to you, the employee. In the event Discover determines, in its discretion, that you are unable to care for your affairs due to disability or otherwise, Discover may make payment to such other person on your behalf as Discover determines to be appropriate.

Any such payment shall be in full satisfaction of any benefit due to you.

Discover has the right to recover any overpayment, including any overpayment due to:

- Fraud
- Mistakes in payment or errors in processing a claim
- Your receipt of any monetary award or settlements from a third party as a result of your disability
- Your receipt of any state-mandated benefits

You must reimburse Discover in full for any overpayments. Discover will determine the method by which repayment shall be made, which may include payroll or other benefit deductions to the extent permitted under applicable law.

Recurrent Disability

A recurrent disability is one that Leave Administration determines has resulted from the same or related illness as a prior disability, during a specified period of time. If you have a successive period of disability due to the same or related cause as your prior disability after you have returned to work on a full-time (or part-time, if you previously worked part-time) basis (other than an alternative work duty assignment) for 30 calendar days or less, benefits will begin immediately. Your recurrent disability will be subject to the same plan terms as your prior disability.

If Leave Administration determines that your successive period of disability is unrelated to your prior disability or you have returned to work for more than 30 calendar days, your later disability will be subject to all of the STD provisions.

During an approved STD leave, Leave Administration may approve your return to work on a full-time or part-time basis, if you previously worked on a part-time basis (other than an alternative work duty assignment) for 30-calendar day or less, benefits will begin immediately. Such an assignment is intended to promote your recovery and return to your own job following a disability-related absence.

Alternative Work Duty

During an alternative work duty assignment, you may:

- Perform your regular duties on a reduced work schedule
- Work on a full-time basis but perform modified job duties
- Perform the duties of some other temporary assignment for which you are qualified because of your education, training or experience on either a full-time or part-time basis

In some circumstances, such as when Leave Administration determines that a short-term modification of your job responsibilities is appropriate, a temporary alternative work duty assignment may be approved for partial disability before you begin an anticipated period of disability under the plan.

A temporary alternative work duty assignment may last for up to 25 weeks. Each assignment will be reviewed by myHR periodically, but at least once every four weeks. You will be considered disabled according to the plan during a temporary alternative work duty assignment as long as you satisfy the conditions of the assignment and the requirements of the plan and the assignment continues to be available. During the assignment, you will be paid for the hours that you work at 100% of your normal rate of base pay as in effect immediately prior to the date you became disabled. For the hours that you do not work, STD benefits will be paid in accordance with the plan's terms. In no event will your rate of pay for hours worked plus any STD benefits paid during a temporary alternative work duty assignment exceed 100% of your pre-disability base pay rate in the aggregate.

If Leave Administration determines that you are unable to resume the normal responsibilities and work

schedule of your regular position at the end of a temporary alternative work duty assignment, you may be eligible to continue to receive STD benefits. In that case, your continued absence from work following an alternative work duty assignment would be considered a continuation of the original period of disability.

Return to Work and FMLA

In order for you to return to work, you will need to provide the administrator with a fitness for duty release form signed by your physician. You will not be allowed to return to work without this documentation. You must notify your manager or HR representative and Leave Administration immediately when you return to work in any capacity.

Contact Leave Administration or your HR representative for eligibility requirements and details about job reinstatement protection under the Family and Medical Leave Act of 1993 (FMLA).

Additional information about your FMLA rights is available in the Discover Family and Medical Leave Policy found on myHR .

STD Exclusions

STD benefits are not paid for any disability incurred in connection with:

- An occupational injury or illness covered by Workers' Compensation law
- Cosmetic surgery (defined as procedures or services that change or improve appearance without significantly improving physiological function) except for reconstructive surgery or gender reassignment surgery and the subsequent cosmetic surgery to enhance the transformation, as determined by Leave Administration and the medical plan.
- An intentionally self-inflicted injury
- Any act of war, declared or undeclared
- Active participation in a riot
- Suspension, revocation or surrender of a professional license, occupational license or certification
- Any period of time during which you are incarcerated
- Any loss to which a contributing cause was your commission of or attempt to commit a felony, or your being engaged in an illegal operation

STD Coverage While on an Unpaid Leave of Absence

If you become disabled while on a non-medical personal leave, you are not eligible for STD benefits. However, you may be eligible for STD benefits while on a medical personal or FMLA leave.

Termination of Coverage

Your STD coverage will terminate on the earliest of the following:

- The date your employment with Discover terminates for any reason
- The date you fail to repay any state-provided benefits to Discover
- The date you are no longer eligible for coverage as determined by Discover
- The date the plan or disability program is terminated

If you notify Discover that you are disabled after announcing your resignation or receiving notice of termination, your STD disability benefits will end on the otherwise scheduled communicated date of termination from Discover. However, if you become disabled and provide notice of disability to Leave Administration as described in the Requesting Payment of STD Benefits section before you either announce your resignation or receive notice of termination, you will remain eligible to receive STD benefits beyond your otherwise scheduled date of termination except as described above. Your date

of termination will be automatically deferred until the date your STD coverage ends. If your STD is extended, your date of termination will be extended to the approved STD end date.

Note: Certain provisions apply for any eligible employee in a WARN period.

Your right to STD benefits may be denied or terminated by Leave Administration, if it denies your claim, if you fail to provide evidence of disability or any other information requested by Leave Administration, or if Leave Administration determines that you are capable of performing your job despite your medical condition. Additionally, Leave Administration may terminate your STD benefits if Discover terminates your employment for “cause” or following the termination of your employment for any reason Discover determines that your employment could have been terminated for cause, in either case as determined by Discover in its discretion.

Long-Term Disability (LTD) Insurance

Discover’s LTD insurance coverage gives you an opportunity to protect 60% of your health and welfare eligible earnings (HWEE) for exempt employees or 50% of your HWEE for non-exempt, as defined in the HWEE section, up to a maximum benefit of \$20,000 per month. LTD insurance is provided by CIGNA. CIGNA refers to CIGNA Group Insurance, a division of CIGNA Corporation. The policy is underwritten by Life Insurance Company of North America, a CIGNA company. LTD insurance coverage is summarized in CIGNA’s certificate of insurance, which is a supplement to this SPD and can be found on myHR.

If you elect to participate in LTD coverage, you are eligible to receive LTD benefits after being on an approved disability for 180 consecutive days (the “elimination period”).

Enrollment and Eligibility Waiting Period

Non-exempt employees are eligible to make LTD elections as part of the newly eligible enrollment event. Participation in LTD will not begin until six months following eligibility for the Discover Welfare Benefits Plan. This is called the eligibility-waiting period. The eligibility-waiting period is the period of time you must be in active service to be eligible for coverage. Your eligibility-waiting period will be extended by the number of days you are not in active service. If you fail to opt out of LTD coverage when first eligible, you will be enrolled in such coverage and must remain in such coverage until the following annual enrollment, effective the first of the following plan year, or with a qualified life event if reported on a timely basis.

Evidence of Insurability (EOI)

EOI requires you to submit an application of good health to CIGNA before you may participate in LTD coverage. CIGNA may deny your request for LTD coverage if its EOI requirements are not met. If EOI is required, your enrollment in LTD coverage will not be effective until your EOI is approved by CIGNA.

Pre-Existing Condition Exclusion

CIGNA will not pay benefits for any period of disability caused by, or resulting from, a pre-existing condition. A pre-existing condition means any injury or sickness for which you incurred expenses, received medical treatment, care or services, including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a physician within three months before your most recent effective date of insurance.

If you become disabled:

- As a result of a medical condition that is not related to your pre-existing condition, you will be eligible for disability benefits provided you meet the conditions of LTD coverage
- As a result of a pre-existing condition and the disability begins within the first 12 months after first becoming eligible for LTD coverage, you may not be eligible for disability benefits for that medical condition
- After 12 months, pre-existing conditions will not limit your coverage and you will be eligible for disability benefits for any medical condition provided you meet the conditions of LTD benefits coverage

“Active at Work” Rule

Under the LTD Program, the active at work rule applies. If you are ill or injured and away from work on the day your coverage was scheduled to become effective, the effective date of coverage and any premium due for such coverage will be deferred to the date you return to work for one full day.

LTD Benefits

LTD benefits provide a monthly income to you after you have been disabled for at least 180 consecutive days (the “elimination period”). Although you need not be confined in a hospital or an extended health care facility to receive LTD income (other than mental or nervous conditions lasting beyond 24 months), you must be under the regular care of a physician and you must be determined by CIGNA to be disabled.

The monthly benefit amount that you will be paid while you are disabled is calculated as follows:

- 60% of your HWEE (as defined in the “HWEE” section) for exempt employees or 50% of your HWEE for non-exempt employees at the time of disability, offset by other income benefits (as defined in the “Other Income Benefits” section), with a minimum monthly benefit after offsets equal to \$100 or 10% of your gross monthly benefit, whichever is greater
- Up to a maximum benefit of \$20,000 per month

When combined with other income benefits, if any, the monthly LTD benefit may not exceed 60% of your HWEE for exempt employees or 50% of your HWEE for non-exempt employees. No federal or state taxes will be withheld from your benefit.

Eligible pay as defined in the “Health and Welfare Eligible Earnings” section is limited to \$400,000.

Definition of Disability

For the first 24 months following your 180-day elimination period, you are disabled if CIGNA determines that you are:

- Unable to perform the material duties of your regular occupation, and
- Unable to earn 80% or more of your indexed earnings from working in your regular occupation.

After receiving LTD benefits for 24 months, you are disabled if CIGNA determines that you are:

- Unable to perform the material duties of any occupation for which you are, or may reasonably become, qualified based on education, training or experience; and
- Unable to earn 80% or more of your indexed earnings¹

You will continue to receive a monthly benefit up to the program’s maximum benefit period (as defined in the “Maximum Benefit Period” section) as long as you continue to be disabled as determined by CIGNA.

Your disability must result from:

- Accidental bodily injury
- Sickness
- Mental illness
- Substance abuse
- Pregnancy

¹ Definition of Indexed Earnings

For the first 12 months monthly benefits are payable, your indexed earnings are equal to your covered earnings (HWEE). After 12 months benefits are payable, your indexed earnings are your covered earnings (HWEE) plus an increase applied on each anniversary of the date monthly benefits become payable. The amount of each increase will be the lesser of:

- 10% of your indexed earnings during your preceding year of disability; or
- The rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.

Elimination Period

The elimination period is the number of days that must elapse during a period of disability before LTD benefits become payable. The elimination period for LTD coverage is 180 consecutive days.

LTD Exclusions/Change in Coverage

LTD benefits are not paid for any disability incurred in connection with:

- Suicide, attempted suicide or self-inflicted injury while sane or insane
- Any act of war, declared or undeclared
- Active participation in a riot
- The revocation, restriction or non-renewal of a license, permit or certification necessary to perform the duties of your occupation unless due solely to injury or sickness otherwise covered by the LTD policy
- Any period of time during which you are incarcerated in a penal or corrections institution
- Any loss to which a contributing cause was your commission of or attempt to commit a felony, or your being engaged in an illegal operation or activity
- Any loss excluded by name or specific description in the insurance policy

In certain circumstances, you may not be eligible for LTD insurance coverage even if you have paid premiums for such coverage. If coverage is provided in error and it is later determined that you were not eligible for LTD insurance coverage due to failure to obtain EOI, meet the active at work rule or for some other reason, you shall receive a full refund of any insurance premiums you have paid in error. You shall have no right to a claim for LTD insurance from CIGNA, the plan or Discover.

Maximum Benefit Period

Your LTD benefits continue for as long as you remain disabled (see the “Definition of Disability” section), subject to the following maximum benefit periods:

MAXIMUM DURATION OF BENEFITS	
AGE WHEN DISABILITY BEGINS	MAXIMUM BENEFIT PERIOD
UNDER AGE 60	THE EMPLOYEE'S 65TH BIRTHDAY OR THE DATE THE 60TH MONTHLY BENEFIT IS PAYABLE, IF LATER
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

Mental Illness Limitation

CIGNA will pay disability benefits on a limited basis during your lifetime for a disability caused by any one or more of the following conditions. Once 24 monthly disability benefits have been paid, no further benefits will be payable for any of the following conditions:

- Anxiety disorders
- Delusional (paranoid) disorders
- Depressive disorders
- Eating disorders
- Mental illness
- Somatoform disorders (psychosomatic illness)

If, before reaching your lifetime maximum benefit, you are confined in a hospital for more than 14 consecutive days, that period of confinement will not count against your lifetime limit. The confinement must be for the appropriate care of any of the conditions listed above.

Limited Benefit Periods for Alcoholism and Drug Addiction or Abuse

CIGNA will pay disability benefits on a limited basis during your lifetime for a disability caused by any one or more of the following conditions:

- Alcoholism
- Drug addiction or abuse

Once 24 monthly disability benefit payments have been paid, no further benefits will be payable for any of the following conditions.

If, before reaching your lifetime maximum benefit, you are confined in a hospital for more than 14 consecutive days, that period of confinement will not count against your lifetime limit. The confinement must be for the appropriate care of any of the conditions listed above.

Other Income Benefits

Other income benefits are benefits paid to you separately from your LTD benefit. They may also include benefits paid to your family or to a third party or assumed to be received, as described below, on your behalf. These may include, but are not limited to: retirement or pension benefits; veterans' benefits; workers' compensation benefits; Social Security benefits; or other governmental benefits.

Assumed Receipt of Benefits

CIGNA will assume you (and your dependents, if applicable) are receiving benefits for which you are eligible from other income benefits. CIGNA will reduce your disability benefits by the amount from other income benefits it estimates are payable to you and your dependents.

CIGNA will waive assumed receipt of benefits, except for disability earnings for work you perform while disability benefits are payable, if you:

- Provide satisfactory proof of application for other income benefits;
- Sign a reimbursement agreement;
- Provide satisfactory proof that all appeals for other income benefits have been made unless the CIGNA determines that further appeals are not likely to succeed; and
- Submit satisfactory proof that other income benefits were denied.

CIGNA will not assume receipt of any pension or retirement benefits that are actuarially reduced according to applicable law, until you actually receive them.

If you are paid other income benefits in a lump sum or settlement, you must provide proof satisfactory to CIGNA of the amount attributed to loss of income and the period of time covered by the lump sum or settlement. CIGNA will prorate the lump sum or settlement over this period of time. If you cannot or do not provide this information, CIGNA will assume the entire sum to be for loss of income, and the time period to be five years. CIGNA may make a retroactive allocation of any retroactive other income benefit. A retroactive allocation may result in an overpayment of your claim.

The amount of any increase in other income benefits due to a cost of living adjustment will not be included as other income benefits if such increase takes effect after the first reduction is made for any other income benefits. This does not apply to any cost of living adjustment for disability earnings.

Recurrent Disability

A recurrent disability is one which results from the same or related illness as a prior disability, for which a monthly benefit was payable, during a specified period of time. CIGNA will consider a successive period of disability to be a recurrent disability if it is due to the same or a related cause and occurs less than six months after the end of the previous period of disability. If you have an approved recurrent disability, you do not have to satisfy an additional 180-day elimination period.

If the disability does not meet the recurrent disability terms described above, it will be considered a new disability. You will be required to complete a new 180-day elimination period before LTD benefits become payable. You may be eligible for STD benefits during the first 180 consecutive days of your disability under STD (see the “Short-Term Disability” (STD) Benefits section).

Work Incentive Benefit

While you are disabled, as defined in the Definition of Disability section, you are permitted to work upon receiving approval from CIGNA.

If you are disabled, to encourage your return to work, CIGNA provides a work incentive benefit for 24 months. During any month you have disability earnings, benefits are determined as follows:

During the first 12 months:

1. Add your gross disability benefit and disability earnings
2. Compare the sum from 1 to your indexed earnings
3. If the sum from 1 exceeds 100% of your indexed earnings, subtract the indexed earnings from the sum in 1
4. Your gross disability benefit will be reduced by the difference from 3 as well as by other income benefits
5. If the sum from 1 does not exceed 100% of your indexed earnings, your gross disability benefit will be reduced by other income benefits

After disability benefits are payable for 12 months, the monthly benefit payable is the gross disability benefit reduced by other income benefits and 50% of disability earnings.

No disability benefits will be paid, and insurance will end if CIGNA determines that you are able to work under a modified work arrangement and you refuse to do so without good cause.

Survivor Benefit

You will receive a survivor benefit if you die while disability benefits are payable to you for a continuous period of disability. The survivor benefit will equal 100% of the sum of the last full disability benefits payable to you plus the amount of any disability earnings by which the benefit had been reduced for

that month. A single lump sum payment equal to 3 monthly survivor benefits will be payable to your spouse. If you do not have a spouse, surviving children will receive an equal share. If you do not have a spouse or any children, it will be paid to your estate.

For purposes of LTD insurance, spouse means lawful spouse (includes same gender spouse as applicable under state law). For purposes of LTD insurance, children means your unmarried children under age 21, who are chiefly dependent upon you for support and maintenance. The term includes a stepchild living with you at the time of your death.

Continuation of Other Health and Welfare, Retirement and Savings and Other Benefits

When you are employed with Discover and are receiving LTD benefits, you are placed in an unpaid leave status and are eligible for continuation of certain other health and welfare, retirement and savings and other benefits. These include the continuation of the following benefits, if you were enrolled in them immediately prior to your disability (subject to your continued contributions, where applicable):

- Medical, dental and vision programs
- Critical illness insurance
- If you are approved for U.S. Social Security disability insurance and Medicare due to your disability, Medicare is considered your primary medical program coverage and the Discover medical program (if enrolled) will be your secondary coverage. You will need to submit your expenses to Medicare first. Once Medicare has determined how much it will pay, you may submit any uncovered expenses to Discover's plan. To receive maximum medical coverage, it is important to enroll in Medicare Part B because your benefits under the medical program will be computed as though you have received Medicare Part B benefits, even if you have not enrolled in this coverage. This is not the case with Medicare prescription drug coverage.
- Health Care Flexible Spending Account (through the end of the calendar year that you began receiving LTD benefits)
- Life insurance program (including both basic and supplemental, up to a maximum age of 65)
- Accrual of vesting service under the Discover Financial Services Pension Plan, if eligible
- Discover 401(k) Plan; however you will only receive a company and/or fixed match if you have eligible pay
- Employee Stock Purchase Plan (ESPP)
- MetLife group auto, home and pet insurance
- Legal assistance program

The following benefits will cease when you begin receiving LTD benefits:

- Accidental death and dismemberment (AD&D) insurance (including basic and supplemental)
- Business travel accident (BTA) insurance
- Dependent Day Care Flexible Spending Account, and
- Commuter benefits program
- Short-term disability (STD)

While on an unpaid leave, including for disability, Discover may terminate your employment subject to its unpaid leave policies and applicable law. Contact your HR representative or visit myHR for more information.

Upon termination of employment with Discover, through COBRA you may be eligible to continue your medical, dental and vision benefits for up to 18 months and your Health Care FSA through the end of the calendar year. In the case of certain other qualifying events, qualified beneficiaries may have the opportunity to maintain continuation coverage for up to 36 months. An 18-month period of continuation may be extended for up to 11 additional months (for a total of up to 29 months) if you or your qualified beneficiary has been determined to be disabled (under Title II or XVI of the Social Security Act) as of the date of your termination of employment and if you notify myHR (acting on behalf of the plan administrator) within 60 days of such determination (and within the initial 18-month continuation coverage period). The 11-month extension is also available to your nondisabled family members who are entitled to continuation of coverage.

This notice is a summary of the law and therefore is general in nature. The law itself and the actual plan provisions must be consulted with regard to the application of these provisions in any particular circumstance. See the “Continuation Coverage Rights under COBRA” section and if you have any questions about COBRA, contact myHR at 844-DFS-myHR **(844-337-6947)**.

Basic life insurance continues until the earlier of the date you stop receiving LTD benefits, the date you reach age 65 or your settlement effective date if you receive a lump sum settlement from CIGNA. All other benefits generally cease at your date of termination from Discover.

If you are receiving LTD benefits and are under age 65, you may continue your supplemental life insurance coverage by paying the same rates as active employees. This does not apply to dependent life insurance coverage. You will be billed monthly by myHR. Upon termination of your LTD benefits or attaining age 65 you may convert your supplemental life insurance to an individual policy.

Premiums While on LTD

Your premiums for LTD coverage will be waived while LTD benefits are payable.

Termination of LTD Benefits

LTD benefits will stop:

- When you are no longer disabled
- In the event of your death
- When you reach the maximum benefit period, as described in the Maximum Benefit Period sub-section, including the mental illness limitations
- On the date your current earnings equal or exceed 80% of your pre-disability earnings
- On the date you refuse the care of a physician which is appropriate for the condition causing your disability and which is intended to help you return to work in your occupation
- The date you refuse, without good cause, to fully cooperate in all required phases of the rehabilitation plan and assessment

In addition, CIGNA reserves the right to terminate your LTD benefits if you fail to provide evidence of disability or any supplemental information requested by CIGNA.

Conversion

If you are an exempt employee, you may be eligible to convert your Group Long-Term Disability coverage to an individual policy (generally, the lesser of 60% of your current monthly earnings or \$5,000 per month) without providing evidence of insurability.

LEGAL ASSISTANCE PROGRAM

The Discover legal assistance program provides participating employees and their families with direct access to attorneys for personal legal matters. Program members can obtain services from in-network local attorneys; in-network attorney's fees for covered services are fully covered by the program. Alternately, members can use any out-of-network attorney and be reimbursed for covered services up to set amounts in accordance with the out-of-network fee reimbursement schedule. The legal assistance program is administered by Hyatt Legal Plans (Hyatt Legal), a MetLife Company.

The legal assistance program offers:

- Access to over 13,000 in-network attorneys
- Telephone consultations
- Office consultations
- Coverage for many personal legal matters
- Instant online access to Hyatt Legal's attorney locator and common legal forms

Enrollment

Enrollment is available on myHR when newly eligible, with a qualified life event that allows enrollment, or during annual enrollment held in the fall of each year.

How to Access Legal Services

Access to the legal assistance program is available at Hyatt Legal's website (metlife.com/mybenefits) or by calling the Hyatt Legal Plan's Client Service Center at 800-821-6400. Once enrolled in the program, members will be asked for the last four digits of the Social Security number (SSN) and ZIP code to establish enrollment. If you are a spouse or domestic partner or an eligible dependent child, you will need the employee's information when calling in.

In-Network/Internet Access

- Log on to metlife.com/mybenefits.
- Click on Group Legal.
- Enter last four digits of your SSN and ZIP code.
- Click on Covered Service to confirm that your legal matter is covered (your network attorney will make the final determination).
- Click on Attorney Locator to find a list of convenient network attorney offices.
- Click on Obtain Case Number to get the case number your network attorney will need to provide service. You will need a new case number for each new legal matter you have.

Client Service Center

- Contact the Hyatt Legal Plans Client Service Center at **800-821-6400** Monday–Friday, 8 am to 7 pm, Eastern Time.
- They will ask for the spelling of your last name, the last four digits of your Social Security Number and your zip code. The client service representative will confirm your eligibility and will make an initial determination of whether and to what extent your legal matter is covered (your network attorney will make the final determination) and will provide you with the phone numbers for several convenient network attorney offices.
- The client service representative will provide you with a case number to provide to your network attorney. You will need a new case number for each new legal matter you have.

Then call the network attorney to schedule an appointment. Evening and Saturday appointments are available. When making your appointment indicate that you are a new client, a member of the legal assistance program (administered by Hyatt Legal) and provide the last four digits of your Social Security Number and your case number.

Out of Network

If you choose, you may select your own attorney. The legal assistance program will reimburse you for your out-of-network attorneys' fees for covered services in accordance with the fee schedule, outlined in the "Out-of- Network Fee Reimbursement Schedule" at the end of this section.

For out-of-network services to be covered, you or your eligible dependent must first obtain a Claim Form (which includes the Case Number) by calling the Hyatt Legal Plans Client Service Center. The client service representative will confirm your eligibility and will send you a claim form and current fee reimbursement schedule on your request.

Claim forms for reimbursement of eligible out-of-network services are available by calling the Hyatt Legal Plans Client Service Center.

Covered Services

The legal assistance program entitles you and your eligible dependents to receive certain personal legal services. Most common types of legal matters are covered, but there are limitations and conditions. Please take time to read the description of services carefully.

All services are available to you and your eligible dependents, unless otherwise noted.

For in-network or out-of-network services to be covered, you or your eligible dependents must have obtained a case number or claim form, retained an attorney and the attorney must begin work on the covered legal matter while you are an eligible participant in the legal assistance program.

Note: U.S. expatriates or U.S. benefits-eligible international employees who receive pay from a U.S. dollar-based payroll, may use the out-of-network option for services provided by an overseas attorney. Reimbursement checks will be in U.S. dollars and any necessary currency conversions are made as of the date of the attorney's invoice.

Consultation and Advice

In addition to the covered legal services, the legal assistance program offers you the opportunity to discuss with an attorney any personal legal problems. However, certain exclusions apply. See the "Exclusions" section for those exclusions. The network attorney will explain your rights, point out your options and recommend a course of action. The network attorney will identify any further coverage available under the program, and will undertake representation if you request. If representation is covered by the program, you generally will not be charged for the network attorney's services. If representation is recommended, but is not covered by the program, the network attorney will provide a written fee statement in advance. You may choose to retain the network attorney at your own expense, seek other counsel, or do nothing.

There are no restrictions on the number of times per year you may use this service; however, for a non-covered matter, this service is not intended to provide you with continuing access to a network attorney in order to seek advice that would allow you to undertake your own representation.

Consumer Protection Matters

The legal assistance program provides you with representation (as a plaintiff), including trial, in disputes over consumer goods and services where the amount contested exceeds the small claims court limit in your jurisdiction and is documented in writing. The controversy must be evidenced by a written document such as a sales slip, contract, note or warranty. This service does not include disputes over real estate, construction, insurance or collection activities after a judgment.

Personal Property Protection

This service covers over-the-phone or in-office counseling on any personal property issue such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements. Counseling on pursuing or defending small claims actions is also included. The service also includes reviewing any personal legal documents and preparing promissory notes, affidavits and demand letters.

Small Claims Assistance

Provides you with counseling on prosecuting a small claims action; helps you prepare documents; advises you on evidence, documentation and witnesses; and prepares you for trial. The service does not include the network attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

Debt Collection Defense

Provides you with an attorney's services for negotiation with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, foreclosure, repossession or garnishment, up to and including trial if necessary. It includes a motion to vacate a default judgment. It does not include counter, cross or third party claims; bankruptcy; any action arising out of family law matters including support and post-decree issues; or any matter where the creditor is affiliated with Discover, Hyatt Legal or their affiliates.

Identity Theft Defense

Provides you with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides you with defense services for specific creditor actions over disputed accounts. Defense services include limiting creditor harassment and representing you in defense of any action that arises out of identity theft such as foreclosure, repossession or garnishment, up to and including trial if necessary. The service also provides you with online help and information about identity theft and prevention through the Hyatt Legal Plans website. It does not include counter claims, cross claims, or third party claims; bankruptcy; any action arising out of family law matters, including support and or post-decree matters, or any matter where the creditor is affiliated with Discover, its affiliates or the employer.

Tax Audits

Covers reviewing tax returns and answering questions the IRS or a state or local taxing authority has concerning your tax return; negotiating with the agency; advising you on necessary documentation; and attending an IRS or a state or local taxing authority audit. The service does not include prosecuting a claim for the return of overpaid taxes, or the preparation of tax returns.

Administrative Hearing Representation covers your defense of civil proceedings before a municipal, county, state or federal administrative board, agency or commission; including a hearing before an administrative board or agency over an adverse governmental action. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters, or litigation of a job-related incident.

Civil Litigation Defense

Covers your defense of an arbitration proceeding or civil proceeding before a municipal, county, state or federal administrative board, agency or commission, or in a trial court of general jurisdiction. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family matters, post judgment matters, matters with criminal penalties, or litigation of a job-related incident. Services do not include bringing counterclaims, third party or cross claims.

Incompetency Defense

Covers your defense of any incompetency action, including court hearings when there is a proceeding to find you incompetent (excluding job-related incompetence actions).

Document Preparation

Affidavits

Covers the preparation of any affidavit in which you are the person making the statement.

Deeds

Covers the preparation of any deed for which you are either the grantor or grantee.

Demand Letters

Covers the preparation of letters that demand money, property or your other property interest, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to you. Negotiations and representation in litigation are not included.

Mortgages

Covers the preparation of any mortgage or deed of trust for which you are the mortgagor. This service does not include documents pertaining to business, commercial or rental property.

Promissory Notes

Provides for preparation of any promissory note for which you are the payer or payee.

Document Review

Provides review of your personal legal documents, such as letters, leases or purchase agreements.

Family Law

Name Change

Covers all necessary pleadings and court hearings for your legal name change.

Prenuptial Agreement

Includes the preparation of an agreement by a participating employee and his or her fiancé(e)/domestic partner prior to their marriage (or legal union, where allowed by law), outlining how property is to be divided in the event of separation, divorce, termination of civil union or death of a spouse or domestic partner. It does not include subsequent litigation arising out of a prenuptial agreement. Representation is provided only to a participating employee. The fiancé(e)/domestic partner must have separate counsel or must waive representation.

Protection from Domestic Violence

Covers a participating employee only, not the spouse or domestic partner or dependents, as the victim of domestic violence. It provides a participating employee with representation to obtain a protective order, including all required paperwork and attendance at all court appearances. The service does not include representation in suits for damages, defense of any action, or representation for the offender.

Elder Law Matters

This service covers over-the-phone or in-office counseling on any personal issues relating to the participating employee's parents as they affect the employee. The service includes reviewing documents such as Medicare or Medicaid materials, prescription plans, leases, nursing home arrangements, powers of attorney, living wills and wills. The service also includes preparing deeds involving the parents when the participant is either the grantor or grantee and preparing promissory notes involving the parents when the participant is the payer or payee.

Uncontested Adoption

Covers all uncontested legal services and court work in a state or federal court for an adoption for a participating employee and spouse or domestic partner. If an adoption becomes contested, a participating employee, spouse, or domestic partner must pay all additional legal fees.

Uncontested Guardianship or Conservatorship

Covers establishing an uncontested guardianship or conservatorship over a person and his or her estate when a participating employee, spouse, or domestic partner is appointed guardian or conservator. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing and preparing the initial accounting. If the proceeding becomes contested, a participating employee, spouse, or domestic partner must pay all additional legal fees. This service does not include representation of the person over whom guardianship or conservatorship is sought, or any annual accountings after the initial accounting or terminating the guardianship or conservatorship once it has been established.

Immigration Assistance

Includes advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents and helping you and your covered dependents prepare for hearings.

Personal Injury (25% Network Maximum)

Subject to applicable law and court rules, network attorneys will handle personal injury matters (where you are the plaintiff) at a maximum fee of 25% of the gross award. It is your responsibility to pay this fee and all costs directly to the network attorney.

Real Estate Matters

Boundary or Title Disputes (Primary Residence)

Covers negotiations and litigation arising from boundary or title disputes involving your primary residence, where coverage is not available under your homeowner or title insurance policies. The service includes filing to remove a mechanic's lien.

Eviction and Tenant Problems (Primary Residence—Tenant Only)

Covers you as a tenant for matters involving leases, security deposits or disputes with a residential landlord. The service includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.

Home Equity Loans (Primary Residence)

Covers the review or preparation of a home equity loan on your primary residence.

Property Tax Assessment (Primary Residence)

Covers review and advice on a property tax assessment on your primary residence. It also includes filing the paperwork; gathering the evidence; negotiating a settlement; and attending the hearing necessary to seek a reduction of the assessment.

Refinancing of Home (Primary Residence)

Includes the review or preparation, by an attorney representing you, of all relevant documents (including the mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in refinancing of or in obtaining a home equity loan on your primary residence. This service includes obtaining a permanent mortgage on a newly constructed home. This benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The service does not include the refinancing of a second home, vacation property, rental property or property held for business or investment or income purposes.

Sale or Purchase of Home (Primary Residence)

Includes the review or preparation, by an attorney representing you, of all relevant documents (including the construction documents for a new home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of your primary residence or of a vacant property to be used for building a primary residence.

The service also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The service does not include the sale or purchase of a second home, vacation property, rental property, property held for business or investment or leases with an option to buy.

Security Deposit Assistance (Primary Residence—Tenant Only)

This service covers counseling you as a tenant in recovering a security deposit from your residential landlord for your primary residence; reviewing the lease and other relevant documents; and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting you in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation and witnesses; and preparing you for the small claims trial. This service does not include the program attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

Zoning Applications

This service provides you with the services of a lawyer to help get a zoning change or variance for your primary residence. Services include reviewing the law, reviewing the surveys, advising you, preparing applications, and preparing for and attending the hearing to change zoning or obtain a variance.

Traffic and Criminal Matters

Juvenile Court Defense

Includes the defense of the participating employee's eligible dependent child in any juvenile court matter, provided there is no conflict of interest between the participating employee and the child. In that event, this service provides an attorney for the participating employee only, including services for parental responsibility.

Traffic Ticket Defense (No DUI or Vehicular Homicide)

Covers your representation in defense of any traffic ticket except driving under influence or vehicular homicide, including court hearings, negotiation with the prosecutor and trial.

Restoration of Driving Privileges

Provides you with representation in proceedings to restore your driving license.

Wills and Estate Planning

Trusts

Includes the preparation of revocable and irrevocable trusts for you. It does not include tax planning or services associated with funding the trust after it is created.

Living Wills

Includes the preparation of a living will for you.

Powers of Attorney

Includes the preparation of any power of attorney when you are granting the power.

Probate (10% Network Discount)

Subject to applicable law and court rules, network attorneys will handle probate matters at a fee 10% less than the network attorney's normal fee. It is your responsibility to pay this reduced fee and all costs.

Wills and Codicils

Includes the preparation of your will. The creation of any testamentary trust is covered. The service includes the preparation of codicils and will amendments. It does not include tax planning.

Exclusions

Excluded services are those legal services that are not provided under the legal assistance program. No services, not even a consultation, can be provided for the following matters:

- Employment-related matters, including company or statutory benefits
- Matters involving Discover and its affiliates, MetLife and its affiliates and network attorneys
- Matters in which there is a conflict of interest between the participating employee and spouse or domestic partner or dependents; in such cases, services are excluded for the spouse or domestic partner and dependents (services are provided only to the participating employee)
- Appeals and class actions
- Farm and business matters, including rental issues when you are the landlord
- Patent, trademark and copyright matters
- Costs or fines
- Frivolous or unethical matters
- Matters for which an attorney-client relationship exists before you become eligible for legal assistance program benefits
- Bankruptcy

Confidentiality, Ethics and Independent Judgment

Use of the legal assistance program and the legal services provided is confidential. The network attorney will maintain strict confidentiality of the traditional lawyer-client relationship. Discover will know nothing about your legal matters or the services you use under the legal assistance program. Discover will have access only to limited, anonymous statistical information for administration of the legal assistance program.

Hyatt Legal and Discover will not interfere with the network attorney's independent exercise of professional judgment when representing you. All network attorneys' services provided under the program are subject to ethical rules established by the courts for lawyers. The network attorney will adhere to the rules of the program and will not receive any further instructions, direction or interference from anyone else connected with the program. The network attorney's relationship and obligation is exclusively with you. Hyatt Legal or the law firm providing services under the program is responsible for all services provided by their attorneys.

The program has no liability for the conduct of any network attorney. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the program. You have the right to retain at your own expense any attorney authorized to practice law in your state of residence.

Network attorneys will refuse to provide services if the matter is clearly without merit, frivolous or for the purpose of harassing another person. If you have a complaint about the legal services you have received or the conduct of a network attorney, call Hyatt Legal Plans at **800-438-6388**. Your complaint will be reviewed and you will receive a response usually within two business days of your call.

You have the right to retain at your own expense any attorney authorized to practice law in the state. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the program.

Other Special Rules

In addition to the coverage and exclusions listed, there are certain rules for special situations. Please read this section carefully.

What if other coverage is available to you?

If you are entitled to receive legal representation provided by any other organization such as an insurance company or a government agency, or if you are entitled to legal services under any other legal plan, coverage will not be provided under this program. However, if you are eligible for legal aid or public defender services, you will still be eligible for benefits under this program, so long as you meet the eligibility requirements.

What if you are involved in a legal dispute with your dependents?

You may need legal help with a problem involving your spouse or domestic partner or your children. In some cases, both you and your child may need an attorney. If it would be improper for one attorney to represent both you and your dependent, only you will be entitled to representation under the program; your dependent will not be covered under the program.

What if you are involved in a legal dispute with another employee?

If you or your dependents are involved in a dispute with another Discover Financial Services participating employee or that employee's dependents, Hyatt Legal will arrange for legal representation with independent and separate counsel for both parties.

What if the court awards attorneys' fees as part of a settlement?

If you are awarded attorneys' fees as a part of a court settlement, the program must be repaid from this award to the extent that it paid the fee for your attorney.

Continuation of Coverage Under the Legal Assistance Program

If you are an eligible employee enrolled in the legal assistance program, when you terminate or retire, you may continue coverage in the legal assistance program at your own expense for 30 months. Contact the Hyatt Legal Client Service Center within 30 days of your loss of coverage. You will be required to pay a fee upfront, directly to Hyatt Legal, equal to the monthly group legal plan rate multiplied by the number of months in the set portability period. Coverage during the portability period is the same as group coverage. Please note that portability is currently a set period of 30 months, but that period is subject to change by Hyatt Legal.

Fee Reimbursement Schedule

This fee schedule describes the maximum amounts that Hyatt Legal Plans will reimburse you for covered legal services provided to you by an attorney not on our panel. Only one fee category per case type applies to each matter (the one that best describes the services that were provided). The legal assistance program provides only for the personal legal matters listed below and once you receive services from an out-of-network attorney, you cannot then use a network attorney for the same matter. If you or your attorney has any questions regarding coverage or exclusions, please visit the Hyatt Legal website at metlife.com/mybenefits or call **800-438-6388** and ask to speak with Hyatt's Payment administrator before services are provided.

The program will reimburse up to a maximum of:

ADVICE AND CONSULTATION		
ADVICE AND CONSULTATION	Office consultation and telephone advice (If no further covered services are provided)	\$70
CONSUMER PROTECTION		
CONSUMER PROTECTION Excludes disputes over real estate, construction or insurance. Disputed amount exceeds small claims limit and is evidenced by writing.	Correspondence and negotiation	\$500
	Filing of suit, ending in settlement or judgment, plus trial supplement ¹	\$2,000
PERSONAL PROPERTY PROTECTION	Counseling, document review and assistance	\$125
SMALL CLAIMS ASSISTANCE	Counseling on preparing small claims complaint and trial preparation	\$200
DEBT MATTERS		
DEBT COLLECTION DEFENSE Excludes defense of matters arising from divorce or post-decree actions. Includes repossession and garnishment.	Negotiation and settlement (Consumer Debts)	\$350
	Negotiation (Foreclosures)	\$500
	Trial, plus trial supplement (Consumer Debts)	\$1,050
	Trial, plus trial supplement (Foreclosures) ¹	\$1,050
	Negotiation and settlement after complaint and answer filed (Consumer Debts)	\$600
	Negotiation and settlement after complaint and answer filed (Foreclosures)	\$850
	Identity theft (correspondence/notice to creditors)	\$250
TAX AUDITS	Negotiation and settlement	\$500
	Audit hearing (includes negotiation and settlement)	\$1,200
DEFENSE OF CIVIL LAWSUITS		
ADMINISTRATIVE HEARING REPRESENTATION AND INCOMPETENCY DEFENSE Excludes defense of matters arising from divorce, post-decree action or other family law matters.	Negotiation and settlement	\$500
	Trial, plus trial supplement ¹	\$1,800
CIVIL LITIGATION DEFENSE Excludes defense of matters arising from divorce, post-decree action or other family law matters.	Negotiation and settlement	\$650
	Trial, plus trial supplement ¹	\$2,000

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¹ Trial supplement—In addition to fees indicated, Hyatt Legal will pay one half of the attorney's hourly rate for representation in trial beyond the second day of trial for a maximum of \$800 per day up to \$10,000 total trial supplement maximum.

DOCUMENT PREPARATION		
DOCUMENT PREPARATION	Document review	\$100
	Affidavits	\$75
	Deeds	\$100
	Demand letters	\$75
	Mortgages	\$70
	Promissary Notes	\$70
FAMILY LAW		
FAMILY LAW	Name change	\$400
	Elder law matters (counseling and document review of only documents pertaining to the participant's parents as affecting the participant)	\$140
	Prenuptial agreement (available to eligible plan member only)	\$750
PROTECTION FROM DOMESTIC VIOLENCE Available to eligible plan member only	Uncontested adoption	\$650
	Uncontested guardianship	\$650
	Preparation of paperwork and attendance at hearing	\$425
IMMIGRATION		
IMMIGRATION ASSISTANCE	Counseling on preparing forms and hearing preparation	\$500
REAL ESTATE MATTERS		
BOUNDARY OR TITLE DISPUTES Primary residence	Negotiation and settlement	\$500
	Trial, plus trial supplement ¹	\$1,500
EVICTION AND TENANT PROBLEMS Primary residence—Tenant only	Correspondence and negotiations	\$280
	Eviction trial defense, plus trial supplement ¹	\$840
HOME EQUITY LOAN Primary residence	Applies only to attorney who represents the plan member, not the attorney representing the lending institution	\$350
PROPERTY TAX ASSESSMENTS Primary residence	Negotiation and settlement	\$270
	File request for hearing with attendance at hearing, plus trial supplement ¹	\$620
REFINANCING OF HOME Primary residence	Applies only to attorney who represents the plan member, not the attorney representing the lending institution	\$350
SALE OR PURCHASE OF HOME Primary residence	Applies only to attorney who represents the plan member, not the attorney representing the lending institution	\$500
SECURITY DEPOSIT ASSISTANCE	Demand letter/negotiations	\$250
	Counseling or preparing small claims complaint and trial preparation	\$150
ZONING APPLICATIONS	Preparation of documentation	\$250
	Documentation/attending hearing	\$500

Continued on next page

¹ Trial supplement—In addition to fees indicated, Hyatt Legal will pay one half of the attorney's hourly rate for representation in trial beyond the second day of trial for a maximum of \$800 per day up to \$10,000 total trial supplement maximum.

TRAFFIC AND CRIMINAL MATTERS		
DRIVING PRIVILEGES/RESTORATION OF SUSPENDED LICENSE	Representation in proceedings to restore license	\$385
JUVENILE COURT DEFENSE	Negotiation and settlement	\$500
	Trial, plus trial supplement ¹	\$1,200
TRAFFIC DEFENSE (NO DUI)	Plea or trial at court for minor moving violations	\$250
	Plea or trial at court for serious moving violations resulting in jail time or license suspension, plus trial supplement ¹	\$500
WILL AND ESTATE MATTERS		
LIVING WILLS	Individual	\$75
	Member and spouse or domestic partner	\$80
POWERS OF ATTORNEY	Individual	\$65
	Member and spouse or domestic partner	\$75
TRUSTS Revocable and irrevocable living trusts	Individual	\$325
	Member and spouse or domestic partner	\$450
WILLS AND CODICILS	Individual	\$150
	Member and spouse or domestic partner	\$200

LONG-TERM CARE INSURANCE

The Discover Long-Term Care (LTC) insurance program, administered and insured by Metropolitan Life Insurance Company (MetLife), is designed to pay for certain expenses in the event you or your eligible covered family members can no longer perform certain everyday activities due to the effects of aging, illness or accident. Coverage extends to the period of time and the place best suited to your needs, whether a nursing home, an adult day care center or at home. Long-term care includes services such as:

- Skilled, intermediate and custodial nursing home care
- Medical treatment or therapy ordered by a physician and provided by a registered nurse or other qualified health care professional
- Assistance with the activities of daily living, such as bathing, eating or dressing, provided by a qualified home health aide

Long-term care coverage is summarized in MetLife's long-term care outline of coverage, which is a supplement to this SPD and can be found on myHR.

Policies issued prior to April 15, 2004, are not sponsored by Discover. For information about pre-April 15, 2004, policies, refer to your LTC Insurance Policy provided to you from MetLife at the time of enrollment or call MetLife at **800-984-8650** for details.

No new enrollments are allowed in the long-term care insurance program. This section only applies to those enrolled after April 15, 2004, and prior to August 1, 2011.

¹ Trial supplement—In addition to fees indicated, Hyatt Legal will pay one half of the attorney's hourly rate for representation in trial beyond the second day of trial for a maximum of \$800 per day up to \$10,000 total trial supplement maximum.

Evidence of Insurability (EOI)

EOI is required if you do not enroll in the long-term care insurance program within the first 90 days of your eligibility effective date. EOI is always required for family members, including domestic partners and new hires who select the 5,000-day total lifetime benefit.

Coverage Options

Daily Benefit Amount

When enrolling, you must first select a Daily Benefit Amount (DBA). The DBA is the maximum amount of daily coverage available for nursing home, in-patient hospice care, assigned living facility and respite care. Your DBA options are:

- \$100
- \$150
- \$200
- \$250

Home health care, ongoing care advisory services, at-home hospice care, assisted living facility and adult day care are all reimbursed up to 75% of the DBA.

If you receive your LTC services abroad and MetLife determines you are eligible to receive benefits, your benefit will be paid on a per diem basis upon completion of the waiting period. The benefit paid will be 50% of the home care DBA. The claim will be paid in U.S. dollars based on the rate of exchange at the time the claim is approved, as determined by MetLife.

Total Lifetime Benefit

Next, you must select a total lifetime benefit. The total lifetime benefit is the maximum amount of benefits the program will pay to or on account of you. Your options are:

- 2,000 days
- 5,000 days

Benefits can last longer than the duration selected based on the cost of your care, how frequently services are needed and what types of services are used. For example, if you select the \$150 DBA and you enter a nursing home that only costs \$125 per day, the difference of \$25 remains toward your total lifetime maximum and extends the duration of your LTC benefit. If you select the \$150 DBA and you receive home health care costing \$60 per day, \$52.50 remains toward your total lifetime maximum and extends the duration of your program benefit (75% of \$150, minus \$60).

Nonforfeiture

When you enroll, you may elect a nonforfeiture feature for a higher premium cost. The nonforfeiture feature allows you to stop paying premiums at a future date and still keep a portion of your coverage. To qualify for nonforfeiture, you must have paid premiums for at least three consecutive years. The feature provides the full DBA with a total lifetime benefit based on the greater of the total amount of premium paid or 30 times the DBA. For example, if you elect the \$150 DBA and pay \$3,500 in premiums over three years and then decide to discontinue the policy, your total lifetime benefit will be based on the greater of \$3,500 (the total amount of premiums paid) or \$4,500 (30 times the DBA).

The transition expense benefit and return of premium upon death feature (see the “Covered Services” section) are not available if you lapse in your coverage and have the nonforfeiture feature.

Inflation Protection

The long-term care insurance program includes an automatic inflation feature. Under this feature, your DBA increases by 5% compounded annually every January 1 with no increase in premium. If your initial effective date of coverage is January 1, your first automatic inflation increase will not occur until the following January 1 and every January 1 thereafter.

Changing Your Coverage Options

You can request a change in your coverage options at any time. Changes in coverage are granted solely by MetLife, in its discretion, and may require EOI.

You can request a change to your LTC coverage as follows:

- Increase DBA (for example, \$100 to \$150)
- Increase total lifetime benefit (for example, 2,000 to 5,000 days)
- Decrease DBA (for example, \$150 to \$100)
- Decrease total lifetime benefit (for example, 5,000 to 2,000 days)
- Add nonforfeiture feature
- Drop nonforfeiture feature

Any change in the cost of coverage will become effective on the first day of the month on or after the date MetLife approves your request. If the change increases your coverage, the cost for the incremental increase will be based on your age on the date the change is effective. If your coverage is decreased, your new cost is based on the age used to determine your previous coverage.

Covered Services

The long-term care insurance program covers the following benefits and services:

Initial Care Advisory Visit

Once you are approved by MetLife to receive benefits, a professional care advisor is available at your option to visit your home and help you assess your long-term care needs and preferences, as well as explore resources and providers in your community. The initial care advisory visit does not count against your total lifetime benefit.

Nursing Home

Coverage includes all levels of care, skilled to custodial, received in a licensed nursing home or Alzheimer's facility.

Nursing home means a facility that is licensed as a nursing facility under the laws of the jurisdiction in which it is located that meets the following criteria:

- Has 24-hour nursing care
- Has 24-hour maintenance or personal care provided by a trained/certified staff supervised by a nurse
- Maintains a written record of services provided to each client
- Has formal arrangements for emergency medical care
- Provides services not limited to provision of food, shelter and other residential services such as laundry
- Residents are not related to the owner or manager of the facility
- Is not, other than incidentally, a hospital (except a distinct part of a hospital which is a nursing facility), a residential facility, hotel, motel, place for rest, home for the aged, sheltered living accommodation, facility for the treatment of mental illness, continuing care retirement community or similar entity or place for drug addicts or alcoholics

Assisted Living Facility

Coverage includes licensed facilities providing 24-hour care and other services required by individuals who are chronically ill and unable to perform the activities of daily living (as defined in the “LTC Benefits” section) or who demonstrate severe cognitive impairment, as determined by MetLife, and have completed the 30 days of covered service waiting period.

Severe cognitive impairment means a deterioration or loss in intellectual capacity that places a person in jeopardy of harming him or herself or others and, therefore, requires substantial supervision by another individual. Deterioration or loss must be measured by clinical evidence and standardized tests that reliably measure impairment in short- or long-term memory, orientation to people, places or time and deductive or abstract reasoning.

Home Care

Coverage includes care received at home from a nurse (R.N., L.P.N. or L.V.N.), home health aide, homemaker and/or a physical, occupational, respiratory or speech therapist from a licensed home care agency. Care can also be received from a nurse or therapist who is not from a licensed agency.

Homemaker means a person whose services are arranged and supervised through a home health care agency and who provides qualified long-term care services. Such services may include light housekeeping, meal preparation or shopping for items needed for qualified long-term care services.

Therapist means a person who maintains a current license or appropriate professional certification to provide therapy services in the jurisdiction in which services are being provided.

Adult Day Care Center

Coverage includes any licensed facility offering care, health support and rehabilitative services for adults during the day.

Adult day care center means a facility operated, licensed and/or certified as an adult day care center under the laws of the jurisdiction in which it is located that meets the following criteria:

- Provides a program of adult day care
- Maintains a written record of services provided to each client
- Has established procedures to obtain emergency medical care
- Is not a place predominantly providing services for recreation or social activities
- Maintains a client-to-staff ratio of 8 (or less) to 1 of which staff includes a full-time director, 1 or more nurses in attendance during operating hours at least 4 hours a day and at least 2 staff members in attendance whenever clients are present

Respite Care

Provides relief for the primary caregiver. Coverage includes care from providers for 21 days per calendar year. Providers include a formal caregiver such as a nurse, care advisor, therapist, home health aide or homemaker, other than an immediate family member.

Hospice Care

Coverage includes health care and support services provided at home or in a licensed hospice facility for those terminally ill as determined by a licensed physician.

Terminal illness or terminally ill means an illness or injury determined by a physician to likely result in a person's death within 6 months.

Ongoing Care Advisory

Coverage includes coordination of care and monitoring of the care you are receiving and assistance with altering your care plan as your needs change.

Transition Expense Benefit

This is a benefit equal to 12 times the DBA. It can be used for items such as durable medical equipment or an emergency response system, in each case as approved by MetLife. It is payable after completion of the waiting period (30 days of covered services) and it does not reduce the total lifetime benefit.

The transition expense benefit is not available if you lapse your coverage and have the nonforfeiture feature.

Alternate Long-Term Care Program of Service

A MetLife care manager can authorize benefits for services that are not specifically defined as covered under the long-term care insurance program. The service must meet the needs of the insured and must be a cost-effective alternative to services otherwise covered under the long-term care insurance program, in each case as determined by MetLife. Contact MetLife for authorization of these benefits.

Bed Reservation Benefit

If you require hospitalization, the long-term care insurance program will continue to pay the DBA for up to 10 days per episode to hold your bed in the nursing home, hospice facility or assisted living facility you were residing in at the date of your hospitalization, if required.

Provider Discounts

Discounts with nursing homes, home health care agencies and medical equipment providers are available throughout the country. These discounts can allow your lifetime maximum benefit to last longer. To take advantage of these discounts, contact MetLife.

Exclusions

The program does not cover the following benefits and services:

- Care specifically provided for detoxification or rehabilitation for alcohol or drug abuse (chemical dependency), except drug abuse sustained at the hands of or while being treated by a physician for an injury or sickness
- Any service or supply received outside the United States or its territories (except as described in the “Coverage Options” section)
- Illness, treatment or medical condition arising out of:
 - War or act of war (whether declared or undeclared)
 - Participation in a felony, riot or insurrection
 - Service in the U.S. armed forces or auxiliary units
 - Attempted suicide (while sane or insane) or intentionally self-inflicted injury
- Treatment provided in a government facility, unless otherwise required by law
- Any care provided while in a hospital, except for confinement in a distinct part of a hospital, which is licensed as a nursing home or hospice
- Any service provided by your immediate family
- Any service or supply to the extent that such expense is reimbursable under Medicare, or would be so reimbursable but for the application of a deductible, coinsurance or copayment amount (this exclusion will not apply in those instances where Medicare is determined to be a secondary payer under applicable law)
- Services for which no charge is normally made in the absence of insurance

Long-Term Care Benefits

You will be considered eligible for benefits when MetLife has determined that you have been certified by a licensed health care practitioner as being chronically ill (and the illness is expected to last at least 90 days) and you have fulfilled a waiting period.

Waiting Period

The waiting period is the amount of time you must wait from the date MetLife determines that you are eligible to receive benefits until the date benefits can be paid to you. The waiting period under the LTC Program is 30 days of covered service.

Chronically ill means

- Being unable to perform, without substantial assistance from another individual, at least 2 out of 6 of the following activities of daily living for at least 90 days due to a loss of functional capacity: bathing, dressing, toileting, continence, eating, transferring, or
- Requiring substantial supervision to protect from threats to health and safety due to a cognitive impairment

Covered services need to be received during the waiting period. No benefits can be paid until the waiting period is satisfied.

Benefits will be paid for services included in a plan of care prescribed by a licensed health care practitioner. A plan of care identifies ways of meeting the qualified LTC benefit.

If you suffer from a disability resulting from organic brain diseases including Alzheimer's disease or a similar disorder, you are eligible for benefits. The plan also pays benefits in cases where your need for long-term care results from mental or nervous disorders, as determined by a licensed physician.

Premium Waiver

If you have been authorized by MetLife to receive a LTC benefit and have fulfilled the 30-day waiting period, MetLife will waive your premium as of the first of the following month. Premium payments will resume on the first day of the month after you are no longer receiving an LTC benefit as long as you have not exhausted your total lifetime benefit.

Reinstatement of Coverage

If coverage is cancelled for nonpayment of premiums, you may request reinstatement within 12 months of the cancellation date. You must provide MetLife with EOI and, if your request is granted, you must pay all past due premiums. If you or your representative can demonstrate to MetLife that you failed to pay premiums solely because of a cognitive impairment or loss of functional capacity, you may request reinstatement within 5 months of the cancellation date without having to provide EOI. You must provide MetLife with proof of the cognitive impairment or loss of functional capacity and pay all past due premiums. The determination of whether or not to reinstate your coverage is made solely by MetLife, in its discretion.

Guaranteed Renewable

As long as you continue to pay LTC premiums, MetLife cannot cancel your coverage.

Termination of Long-Term Care Program Coverage

You can cancel your LTC program coverage at any time. LTC program coverage will end the last day of the month:

- During which you notify MetLife you wish to terminate your coverage, or
- For which MetLife receives your last premium payment

LTC program coverage ends on the date you:

- Reach your total lifetime benefit
- Replace coverage by another substantially similar plan for which you are eligible, or
- Die

In addition, MetLife reserves the right to terminate your LTC program benefits if you fail to provide evidence that you are chronically ill or to provide any supplemental information requested by MetLife.

Continuation of Coverage

If the LTC program ends, you will be able to continue your coverage directly with MetLife if:

- The LTC program is not being replaced with a substantially similar plan
- The LTC program is being replaced with a substantially similar plan, but you are not eligible under the new plan

LIVE AND WORK WELL PROGRAM

Discover recognizes that on occasion, you or your family members may need information or assistance of a personal and confidential nature. We believe that providing a confidential service to help resolve personal issues best serves the interests of you, your family, and Discover. This service is the Employee Assistance Program (EAP). In order to protect confidentiality, EAP services are provided by a third-party vendor, Optum Health. Optum delivers the Live and Work Well program, accessible by telephone and online 24 hours a day, seven days a week. There is no fee to you or your family when you use the EAP.

Optum Health, a division of UnitedHealth Group, has resources, and provides referrals to public and private agencies that provide assistance in areas such as weight management, financial management, substance abuse, stress and family counseling. Through the program, you may gain access to professional assistance directly for yourself and eligible family members. All employee-initiated inquiries are treated confidentiality, and no information is provided to Discover without your consent.

While any expenses incurred by utilizing services referred to by Optum are your responsibility, various types of treatment may be covered under Discover's medical plans. The EAP professional at Optum will assist you in coordinating needed services, but you must file medical claim forms and follow your medical plan option procedures and requirements for coverage to apply.

Eligibility

Discover Live and Work Well is available to all employees and their dependents immediately upon employment.

Objectives

The objectives of the EAP are to:

- Assist employees and eligible dependents with personal, emotional, family and work-related issues;
- Provide counseling or other appropriate resources and referrals;
- Maintain and protect individual confidentiality to the maximum extent practicable through direct access to an independent EAP provider; and
- Enhance employee's productivity and assist them to lead meaningful and healthy lives.

For more information, contact Live and Work Well directly at **800-622-7276**, or visit them at **liveandworkwell.com** (access code: **Discover**).

Benefits Summary

Live and Work Well is Discover's free, confidential resource and referral service for employees, their spouses, domestic partners, and families. Optum also offers traditional EAP services, including:

- Ability to log in to **liveandworkwell.com** and download hundreds of educational materials;
- Ability to personalize the service for your needs;
- Access to Live and Work Well Program from home or anywhere you have a phone or an Internet connection;
- Customized e-newsletters sent to you on a variety of topics; and
- Up to five sessions per issue per year with an Optum or local employee assistance counselor (in person or by phone) to discuss personal or family issues at no charge.

Optum provides help in the areas of:

- | | |
|---------------------------|-----------------------------|
| • Addiction and recovery | • Older adults/elder care |
| • Smoking cessation | • Disability management |
| • Emotional well-being | • Financial management |
| • Health and wellness | • Legal |
| • Parenting and childcare | • Everyday issues |
| • Stress management | • Work |
| • Weight management | • International |
| • Education | • Managing people and teams |
| • Midlife and retirement | |

Confidentiality

This service is provided by Discover and information about an individual's use of Live and Work Well Program is completely confidential. In rare situations, when an employee's job performance or attendance is unsatisfactory and the situation remains uncorrected after supervisory assistance, the employee may be referred by management to the employee assistance program. Such information and records are maintained confidential to the maximum extent possible.

Cost to Employee

There is no cost to you or your eligible dependents for using the Live and Work Well Program. If you use resources or services recommended by Optum, such as a child care center or a treatment program, you are responsible for those costs. Certain treatments may be covered under Discover's medical plans for those individuals who participate in such plans. Contact your medical plan administrator to inquire about coverage for specific mental health or other services in advance of any treatments to ensure you understand plan coverage.

Frequently Asked Questions (FAQs)

Can my dependents use the EAP?

Through Discover's Live and Work Well Program, you may gain access to professional assistance directly for yourself and eligible family members such as your spouse or domestic partner and your children.

Can I receive services outside of the area I live?

Optum Health has a nationwide network of services that you can use. For more information, contact Optum. Assistance is available 24 hours a day, seven days a week.

Does this plan coordinate with my medical plan?

You can have five counseling sessions per issue through the Discover Live and Work Well Program at no charge. If your counseling sessions go beyond the amount covered by the EAP, your medical plan's mental health benefits might pay for some of your expenses. Contact your medical plan administrator to inquire about specific coverage.

Can I continue coverage when I leave Discover?

Yes. Continuation of EAP coverage under COBRA is available for the Discover Live and Work Well Program at no cost to you. Your EAP coverage will stop when your COBRA period ends. See the "Continuation of Coverage under COBRA" section for more details.

What is the maximum number of services/resources I can receive per year?

Telephonic counseling is available 24-7 for situations in which employees need immediate assistance. You can receive five in-person counseling sessions per issue, per calendar year through Optum.

THE COMMUTER BENEFITS PROGRAM

The Commuter Benefits Program (CBP), administered by WageWorks, allows you to use pre-tax dollars to pay for certain work-related commuting expenses:

- Through the CBP, you may purchase transit passes, tickets, vouchers or other transportation media (collectively referred to as "passes") or pay for parking at locations from which you commute to work.
- If your transit or parking expenses are not available for purchase through the CBP, you can have eligible expenses reimbursed directly to you.
- You do not pay federal income tax, Social Security and Medicare tax (FICA), federal unemployment tax (FUTA) or most state and local income taxes on the pre-tax money you direct into the CBP.
- Discover provides a \$60 monthly subsidy for participants in the program (excludes parking).

How the Program Works

The CBP is comprised of two types of commuting expenses:

- Transportation expenses, including qualified fares for riding buses, trains, subways, ferries and other types of mass transportation or vanpools, and
- Parking expenses, including the cost of parking at or near your place of work or at or near a place from which you commute to work by mass transit, such as a park-and-ride lot. The cost of parking at or near your home is not included under any circumstances.

When you enroll in the CBP for eligible transportation expenses, you are authorizing WageWorks to purchase your transit pass directly from your transportation provider. The pass will be mailed to you at home (or at an alternate address you provide directly to WageWorks). If your transit or vanpool arrangement is not available for purchase directly through WageWorks, your pre-tax deduction (up to the allowable IRS dollar limit) will be allocated to a CBP Account and eligible for direct reimbursement to you by WageWorks.

When you enroll in the CBP for eligible parking expenses, you are authorizing WageWorks to pay your parking service directly. If, you pay for parking expenses affiliated with the Discover facility where you work through payroll deduction, are living overseas, or if WageWorks cannot pay the parking facility directly, you can elect to have your pre-tax deduction (up to the allowable IRS limit) allocated to a CBP account to which you can submit claims for direct reimbursement.

You may make both transportation and parking expense elections, but you must elect each separately. If you elect to have WageWorks purchase your pass or pay your parking facility directly and the cost exceeds the pre-tax monthly dollar limit, any additional cost will be deducted from your pay on an after-tax basis.

Your CBP elections may be changed monthly.

Enrollment

To enroll in the CBP, you must make an election at **wageworks.com** or by calling WageWorks at **877-924-3967**, Monday through Friday, 8:00 am to 8:00 pm, Eastern Time.

You can choose to participate in the transportation and/or parking features of the program. You can enroll during any monthly enrollment period as long as you are employed and meet the plan's eligibility requirements. There is no annual "open enrollment" period.

To enroll online, you must register with WageWorks. The first time you access the website select "First Time User? Register Now" on the home page. To verify your eligibility, you will be asked to provide your first and last name, date of birth (mm/dd), the first 5 digits of your ZIP code and the last 4 digits of your Social Security number. If you are a new hire, it may take up to two weeks for your new hire information to become available on the WageWorks website. You may enroll once your information can be verified on the website.

Note: U.S. benefits-eligible employees living overseas must use the ZIP code 10036 to have their eligibility verified.

If you are ordering a transit pass, you must generally make your monthly election by the 10th of the month to ensure delivery of your pass for the following month. Employees in the New York City area purchasing passes for the Long Island Rail Road or Metro-North must place their order by the 4th of the month.

Your payroll deduction is taken once a month from the paycheck you receive on the last business day of the month prior to the benefit month in which you enroll. Once you enroll, your monthly election will continue to be taken from the last paycheck of each month, until:

- You change your election
- You end your participation
- You become ineligible to participate
- Your pay is less than the total amount you elect to contribute

If you do not have enough money in your month-end pay to cover your total requested commuter expense, no payroll deduction will be taken. If no payroll deduction is taken on three separate incidents because of insufficient pay, your participation in the CBP will end and you will not be permitted to have pre-tax deductions taken from your pay. If Discover has already paid money to WageWorks to purchase your pass, pay your parking facility or fund your CBP account, any amount uncollected from your pay will be reported as imputed income on your W-2 Form or 1099.

If your pay changes in the future, contact Payroll to request reinstatement into the CBP. Reinstatement is not guaranteed and is determined by Payroll on a case-by-case basis.

Express Payment Option

If you commute on the Long Island or Metro-North railroads, WageWorks will coordinate your enrollment with your existing Mail&Ride account through the Mail&Ride express payment option. You must have an existing Mail&Ride account to use this payment option. If you do not have a Mail&Ride account, visit the MTA Mail&Ride website at mta.info or call **800-649-6969** for LIRR or **800-638-7646** for Metro-North. When you enroll through WageWorks, you will be required to supply your existing account number, located on your ticket or invoice.

Under the express payment option, you can elect an amount each month (on the WageWorks website) that will be credited towards your Mail&Ride account. This option allows you to continue to receive tax savings for your LIRR or Metro-North ticket, but provides you with the flexibility to manage your Mail&Ride ticket choices through LIRR or Metro-North according to LIRR and Metro-North Mail&Ride cut-off dates. This option also provides you with the flexibility to reduce the amount taken from your paycheck because you can choose for example to only deduct the pre-tax amount.

Changing Your Coverage Elections

To change or stop your election, you must contact WageWorks online or by phone. You must make your elections by the 10th of the month for your change or stop to become effective the following month (unless you are using the Express Payment Option). Employees in the New York City area purchasing passes for the Long Island Rail Road or Metro-North must make their election by the 4th of the month. For example, your election change made on September 3 will be reflected on your September 30 paycheck for the benefit month of October.

Changes made after midnight, Eastern Time, on the 10th (or 4th for Long Island Rail Road and Metro-North) of the current month will be effective for the second following month. For example, if you make a change on September 15 the change will be reflected in your October 31 paycheck for the benefit month of November.

Contribution Limits

By law, you can contribute no more than the following monthly amounts on a pre-tax basis:

- \$130¹ (2015) per month for transportation expenses
- \$250¹ (2015) per month for parking expenses

¹ The monthly limits may be indexed annually (in fixed increments) by the IRS. WageWorks will notify you by e-mail or on its website of any changes in the monthly maximums.

If the cost of your pass or parking facility exceeds the pre-tax dollar amount you elect, any additional cost will be deducted from your pay on an after-tax basis.

If any portion of your transportation amount is subsidized by another Discover program, the pre-tax contribution amount for your transportation pass or parking facility will automatically be reduced by the subsidized portion that you are eligible to receive, not to exceed the IRS limit per month.

Establishing a CBP Account

If your transit pass or parking fee is not available for purchase through WageWorks, you can elect to have transportation and/or parking reimbursement accounts set up through WageWorks. Discover will reduce your taxable base salary and commissions by the amount elected and the amount deducted will be credited to your account. You may submit claims for reimbursement online or by mail or fax to WageWorks on or after the first of the benefit month in which the expense is incurred.

IRS Rules

Federal tax laws require that elections be made on a prospective basis. Accordingly, you may not make an election change after the benefit month has begun.

There are other restrictions you need to keep in mind as you make your elections:

- Expenses incurred only during a month that you were a participant or have an account balance are eligible for reimbursement. Expenses are incurred when you receive the voucher or similar item (parking expenses are incurred at the beginning of the parking month).
- Any unused account balance remaining at the end of each month will be available for use in future months, but the maximum amount you can be reimbursed each month is the lesser of your total account balance and the legal monthly maximum.
- You must submit your claims for reimbursement within 180 days after the expense has been incurred.
- You may not transfer money between the transportation and parking accounts.

Transportation Expenses

You may pay for qualified mass transit or vanpooling expenses through the CBP through pre-tax payroll deductions.

Qualified Mass Transit Expenses

Qualified mass transit expenses include any pass, ticket, token, fare card, voucher or other fares for buses, trains, BART, streetcars, ferries or similar means that entitle you to transportation (or transportation at a reduced price), provided that such transportation is on mass transit facilities. Mass transit may be publicly or privately operated.

Qualified Vanpooling Expenses

Qualified vanpooling expenses are expenses incurred for transportation to and from work and your home, but only if:

- In a “commuter highway vehicle” with seating capacity for at least six adults (not including the driver)
- At least 80% of the mileage use can be reasonably expected to be for the purposes of transportation between work and residences
- On trips during which the number of employees carried is at least one-half of the adult seating capacity of such vehicle (not including the driver)

This can include transportation furnished by Discover.

Monthly Transportation Expense Estimate

You can use the commuter savings calculator available on **wageworks.com** to calculate your monthly transportation needs and to estimate your potential cost savings.

Note to riders of the Long Island Rail Road, Metro-North and WMATA:

If you already have an account with the Long Island Rail Road or Metro-North's Mail&Ride program, there is no need to cancel your existing account before signing up with WageWorks. When you sign up with WageWorks, the railroad will automatically transfer your existing account (unless you elect the express payment option). It is standard for the railroad to send an invoice with the passes they deliver. You can disregard the balance due.

If you live in the Washington, D.C., Metro area and you have an existing WMATA SmarTrip card, you can register the serial number of your card through the WageWorks website. By registering your SmarTrip card, you will be protected if your card is lost or stolen. Information about getting a SmarTrip card can be found on **<http://wmata.com/fares/smartrip>**.

If you purchase a SmarTrip card and currently receive MetroChecks, you will need to cancel your MetroCheck Account.

Passes Not Received

If you do not receive your transportation pass by the first day of the benefit month, purchase your replacement pass and contact WageWorks customer service via e-mail at **help@wageworks.com** or by calling **877-WAGEWORKS**.

You must report any passes not received to WageWorks by the third workday of the benefit month for which the pass is effective. WageWorks will generally reimburse you via a check for the cost of the replacement pass upon receipt of documentation of your expense (for example, a receipt or used transit pass and a completed Special Handling Form). In a rare situation, WageWorks may direct you to contact the agency directly. A Special Handling Form is available from WageWorks Customer Service. Your receipts and Special Handling Form can be faxed to Customer Service—Lost Pass at **650-577-5299**. WageWorks must receive your receipt and completed Special Handling Form by the 10th of the benefit month for which you are claiming reimbursement in order for you to receive reimbursement.

If your original pass arrives after you receive a replacement pass, you must return the original pass to WageWorks. Contact WageWorks for instructions on how to return the pass.

WageWorks will not issue reimbursements for incorrect or incomplete address information, for orders shipped to addresses that are not valid U.S. postal addresses or for orders shipped to P.O. boxes, private post office boxes or mailrooms.

Reimbursements or credit under these terms is your sole remedy for damages incurred as a result of late passes or passes not received.

There will be no charge to you to replace one pass during the calendar year. You will be responsible for the cost of any additional replacement passes.

WageWorks will not issue reimbursement if your pass is lost or stolen after you receive it.

Parking Reimbursement Expenses

You may pay for qualified parking expenses through pre-tax payroll deductions.

Qualified Parking Expenses

Qualified parking expenses are parking expenses you incur at or near the business premises of Discover, which enable you to get to work. Qualified parking expenses also include expenses incurred at or near a location from which you commute to get to work by mass transit, vanpooling, in a commuter highway vehicle or by carpool. Parking expenses incurred at or near your home are not considered qualified expenses.

Monthly Parking Expense Estimate

You can use the commuter savings calculator available on **wageworks.com** to estimate your monthly parking expenses and to estimate any potential cost savings.

Direct Pay for Parking

You can elect to have WageWorks make a payment directly to your parking facility each month (called “Direct Pay”) using your payroll deduction. If the monthly cost of your parking expense is greater than the allowable IRS pre-tax limit, any additional amount will be deducted from your pay on an after-tax basis, up to a \$500 total maximum monthly deduction.

You must request direct payment by the 10th of the month in order for the payment to be made to your parking facility by the first of the following month. For example, if you enter a payment instruction on June 8, WageWorks will mail your Direct Pay payment to your parking provider to ensure it is received in time to post to your parking account for July.

Direct Pay is mailed to the parking facility providers on a monthly basis.

If you pay for your parking on a daily, weekly, quarterly or annual basis, you should establish a parking reimbursement account and submit a claim form so you can be reimbursed for your parking payments.

If you pay for your parking one year in advance, you must file a claim (and a copy of your receipt, if provided) at the beginning of each month for 1/12 of your annual expenses or at the end of each quarter for the prior three months’ expenses.

If you currently have a payroll deduction taken for parking expenses affiliated with the Discover facility where you work, WageWorks cannot pay the parking facility directly. You must establish a parking CBP account and submit a claim for reimbursement.

Ineligible Expenses

By law, the following expenses are not eligible for reimbursement from the CBP:

- Parking or transportation expenses that are not work-related car or vanpooling expenses with fewer than six passenger seats (not including the driver)
- Spouse’s, domestic partner’s or dependent’s parking or transportation expenses
- Tolls (for example, bridges, turnpikes and E-Z Pass)
- Gas
- Mileage allowances or other operating costs for your personal vehicle
- Taxis or limousines
- Traffic tickets
- Payments to a fellow participant in a carpool or to a friend who drives you to work
- Parking at a mall or similar location where you stop on your drive to or from your place of work
- Parking at or near your home (even if you work out of your home)
- Business travel expenses

Requesting Payment of Out-of-Pocket Expenses

After you have incurred an eligible expense, you must request payment by submitting a claim form to WageWorks. An expense is considered incurred when the voucher or similar item is received (parking expenses are incurred at the beginning of the parking month).

All claim forms must be signed and completed in their entirety or the claim will be denied. Claim forms are available online through the Pay Me Back section of the WageWorks website and on the myHR website.

The following information must be documented on each claim form:

- The name of the service provider or type of expense incurred (for example, parking garage)
- Amount of the expense incurred
- The date of service
- Your signature

Receipts must be attached when they are available. Always keep copies of your claim forms and supporting documentation for your files.

Send your completed claim forms to WageWorks by fax to **877-353-9236** or by mail to: WageWorks Claim Administrator, P.O. Box 14053, Lexington, KY 40512. You can view the status of your claim online at **wageworks.com** within 24 hours after it is received.

For reimbursement of expenses that do not have receipts available (for example, metered parking), log on to the WageWorks website and click the tab corresponding to your benefit election (Transit, Vanpool or Parking), click Pay Me Back, then click File Online Claim and provide the information requested. For all other eligible expenses, you will need to submit a paper claim form to WageWorks with receipts.

Federal tax law prevents WageWorks from allowing cash reimbursement through Pay Me Back when a transit pass is readily available for purchase. You can purchase transit passes and submit a paper claim only if:

- The transit pass is not readily available through WageWorks
- The transit pass is not available through WageWorks in the denomination that you purchase from the transit agency

Reimbursements are limited to amounts credited to your account at the time the claim is processed. You can request reimbursement for up to three months of expenses on the same claim form regardless of the balance in your account. However, you will only receive reimbursement up to your available account balance.

Balance Forward Option

If you have a balance in your account for a particular benefit month for which you do not have an eligible expense, you may request that any balance remaining for that benefit month be applied toward your next pending month's election. The request must be made on the claim reimbursement form for that particular month. If you choose this Balance Forward option, your next payroll deduction will be reduced by that benefit month's balance in your account.

In general, claims for reimbursement must be submitted within 180 days after the date the expense was incurred. If you do not file a claim within 180 days of the month in which you made the election, the 180-day old balance will automatically be applied to and reduce your payroll deduction for the next pending month's election.

Method of Reimbursement

Reimbursements for both transportation and parking expenses will be paid to you through your regular paycheck (similar to travel and entertainment expenses). The earnings code "CommReimb" will be used to reflect the reimbursement on your paycheck. This money is not included as part of your gross taxable earnings.

If you terminate and submit claims for reimbursement after your last day worked, your reimbursement will be sent to you directly by check to your home address.

Claim Submission Deadline

Claims must be submitted within 180 days after the expense has been incurred. All claims with dates of service older than 180 days will be denied.

If your employment ends or you otherwise become ineligible to participate in the CBP, you may only submit claims for reimbursement of expenses incurred through your termination date. Any unclaimed balance after 180 days cannot be returned to you and will be forfeited.

For Pay Me Back reimbursements to take place in the same month, WageWorks must receive your claim no later than two business days prior to the 180th of the month. Claims received after that time will be processed for reimbursement in the following month. The reimbursement amount will be paid to you on the last paycheck of the month.

Account Balances

Although you may establish both a transportation account and parking account, each is considered a separate account. Transportation expenses will be paid out of your transportation account and parking expenses out of your parking account. Funds cannot be transferred between accounts. Any unused account balance remaining at the end of each month will be available for reimbursement of future eligible expenses. The maximum amount you can be reimbursed for any month is the lesser of your account balance and the legal monthly maximum. Once your account is activated, you may access and review your account online through the WageWorks website.

SEVERANCE PLAN

Additional SPDs and booklets are available for other benefits offered under the plan, including severance pay and change in control severance benefits. Both the Severance Plan SPD and the Change in Control Severance Policy can be found on myHR.

PAYMENT OF BENEFITS AND CLAIMS AND APPEALS

Claim forms for medical, dental and vision programs are available on the myHR website. Claim forms must be submitted as directed on each form.

Claim forms for critical illness are available on the provider website at metlife.com/mybenefits.

You can submit claims for FSA online at connectyourcare.com. Review the Flexible Spending Accounts section to learn how your contributions to an FSA work.

Claim forms are not required for the HRA Plan. Blue Cross Blue Shield automatically pays claims out of your HRA account as long as you have an available balance.

Claim forms are not required for the HSA Plan. To pay claims out of your HSA account, log on to connectyourcare.com.

Medical Program

For treatment or benefits from a medical program in-network provider, there are generally no claim forms to file. For treatment or benefits from an out-of-network provider, you must submit a claim form to have your expenses reimbursed.

You must request a payment of benefits by submitting a claim form within 90 days of the date the expense is incurred. If it is not reasonably possible to submit the request of payment within this time, more time, not in excess of one year of the date the expense is incurred, will be allowed. Generally, no claim forms submitted more than one year after the date of service will be accepted.

Dental Program

You must request payment of benefits by submitting a claim form to be reimbursed for eligible dental expenses. However, if you identify yourself as a participant in the MetLife PDP program when using a PDP dentist, the dentist may be willing to submit the claim form on your behalf. When using a non-PDP dentist you should bring the claim form with you when you visit the dentist. Claim forms should be submitted directly to your dental program administrator.

You must request a payment of benefits by submitting a claim form within 90 days of the date the expense was incurred directly to your dental program administrator. If it is not reasonably possible to submit the request of payment within this time, more time, not in excess of one year of the date the expense was incurred, will be allowed. Generally, no claim forms submitted more than one year after the date of service will be accepted.

You can view your request for payment status on your dental program administrator's website (see the "Important Benefit Provider Contacts" section for all contact information).

Vision Program

When you receive services from a VSP network doctor, claim forms are not required. When you receive services from an out-of-network provider, you must pay the provider directly for all charges. To request payment of benefits, submit a claim form (include itemized receipts), to:

VSP

P.O. Box 997105

Sacramento, CA 95899-7105

Requests for payment must be submitted within one year of the date of service.

Note: U.S. benefits-eligible expatriates and international employees may fax their claim forms to **916-858-4985**. All claim forms must be submitted in U.S. dollars. Any claim forms received in foreign currency will be converted to U.S. dollars effective as of the date services were received.

Life and Accident Insurance

To request payment of life or accident insurance benefits, you or your beneficiary must contact myHR and submit a certified copy of the death certificate or accident report (or other supporting documentation as required).

myHR will assist you or your beneficiary with requesting payment of benefits by completing claim forms and submitting them to the insurance company.

STD Program

To request payment of STD benefits, you must:

- First, contact your manager to report any absence greater than seven consecutive calendar days.
- Then, call Leave Administration at 844-DFS-myHR (**844-337-6947**). Leave Administration will send you a medical disclosure authorization form. Complete, sign and send or fax the form to Leave Administration. This form allows Leave Administration to contact your physician to obtain needed medical information in order to make a determination of your request. You and your physician will be required to provide information and/or complete certain forms to be submitted directly to Leave Administration.

Note: You must see your physician prior to the seventh consecutive calendar day following your last day worked in order to receive full benefits under the program. Failure to receive prompt treatment from your physician may delay or reduce your benefits.

Leave Administration may not make a determination that you are entitled to STD benefits without your signed medical disclosure authorization form and the necessary information from your physician.

Leave Administration will verify certain information with your manager or HR representative, such as:

- Your last day worked, and
- Your job responsibilities

Leave Administration will verify certain information with your physician, such as:

- That you are under the regular care of a physician
- The date of your disability
- The cause of your disability
- The extent of your disability, including any restrictions and limitations preventing you from performing your regular occupation, and
- The name and address of any hospital or institution where you received treatment, including all attending physicians

If the information required by Leave Administration is not received and a determination is not made within 30 calendar days from your first day absent, you will be placed on an unpaid leave. If your claim is subsequently approved, you will be paid STD benefits retroactively to your first day of approved disability after the waiting period. If Leave Administration does not approve your claim and you do not return to work, your employment may be terminated at Discover's discretion.

Leave Administration may request that you provide proof of continuing disability and that you are under the regular care of a physician. This proof, provided at your expense, must be received as soon as possible (and no later than 15 calendar days after the request) to avoid an interruption in your benefits.

LTD Program

If you have requested payment of STD benefits during your 180-day elimination period, Leave Administration will automatically forward to CIGNA the information provided by you and your physician to Leave Administration for review.

CIGNA will:

- Review the information provided by you and your physician during your STD benefit review
- Request additional information, if needed
- Either accept or deny the claim, and
- Notify you of its determination in a timely manner

If you become disabled while on an unpaid leave or have otherwise not initiated a request for payment of STD benefits, and are participating in LTD, you must contact Leave Administration and CIGNA directly to request payment of LTD benefits. You will be required to complete the 180-day elimination period prior to receiving LTD benefits regardless of whether or not you receive STD benefits.

Legal Assistance Program

A claim form is not required for in-network eligible expenses.

To request payment of out-of-network attorney fees, you must request a claim form prior to receiving service from the out-of-network attorney. Claim forms for reimbursement of eligible out-of-network services are available by calling the Hyatt Legal Plans' client service center.

LTC Program

You, your doctor or representative must contact MetLife and request a determination of benefit eligibility based on your inability to perform the activities of daily living on your own. MetLife must approve the request for benefit eligibility and may also require access to your medical records.

MetLife will pay benefits only upon receipt of written proof deemed adequate by MetLife, in its discretion, that expenses for covered services were incurred. Written proof of claim must be submitted no later than 90 days after the end of the calendar year in which the expenses were incurred. Failure to submit proof of claim within the time limit may result in a claim denial, unless it is shown that it was not reasonably possible, as determined by MetLife, to provide the proof of claim within the time period or that the proof of claim was submitted as soon as reasonably possible. Claim forms are available from MetLife. If MetLife approves the request for payment of benefits, MetLife will send written notice of the decision no later than 10 business days after all necessary information is received.

After MetLife has approved your request for payment, reimbursement for covered services will be paid directly to you. Payments for most services can be made directly to the provider at your request and the request of the providers. This does not include payments for alternate plan of service and/or transition expense benefit as defined in the LTC section.

The Daily Benefit Amount (DBA), selected by you, determines the maximum amount that can be received each day. The amount payable will not exceed the DBA selected for expenses incurred during any day you receive covered services.

Concurrent Review

When you are receiving benefits for covered services, MetLife will review your case from time to time to see that the standards for eligibility to receive benefits are still being met. MetLife may review records and/or contact you, your doctor or someone else familiar with your condition. If it is determined that you are no longer eligible to receive benefits, you will be notified by MetLife.

If Benefits Are Not Paid

If your or your dependent's request for payment under the plan is denied, you or your dependent can file a claim (first review level) and appeal (if the claim is denied). Certain health plans also offer a voluntary third level of review. Information about filing claims and appeals, including applicable timeframes, is included in the following section.

Right to Reimbursement (Subrogation Agreement)

If you or any other person receives a recovery in any form, including (but not limited to) a judgment, settlement, payment or compensation of any type with respect to an injury or condition for which the plan has provided benefits or advanced money (regardless of fault, negligence or wrongdoing) from any tortfeasor, liability insurer, uninsured or underinsured motorist insurer, medical program coverage or other source (a "recovery"), you or such other person must repay the plan in full for any benefits that have been or may be paid, payable or advanced by the plan (the "subrogated amount"), including any reasonably foreseeable expenses not yet incurred, whether or not you or such other person has been "made whole" for the injuries or condition suffered.

Each person receiving benefits or advanced money from the plan has an obligation and duty to reimburse the plan to the extent of the subrogated amount and is deemed to give the plan a first lien

on any recovery for the subrogated amount. The plan may also, in its sole discretion, seek to impose a constructive trust through the courts on a recovery to the extent of the subrogated amount. This right of first priority in contravention of any “make whole” doctrine shall not be affected or limited in any way by the manner in which the person or entity responsible for paying any recovery designates or characterizes the recovery. The plan specifically disclaims the “common fund doctrine” and any payment of the subrogated amount to the plan shall be without reduction, set-off or abatement for attorneys’ fees or costs incurred by you or any other person in obtaining the recovery. You or any other claimant of a recovery must promptly inform the plan of the filing of a lawsuit, making a claim against any third party, the scheduling of settlement negotiations or the intention of any third party to make payment of any kind to your benefit or on your behalf to which this section may reasonably apply. If it is determined that a third-party may be responsible for the payment of benefits paid or money advanced by the plan, you or any other person may be contacted by the plan or its representative to provide information regarding any potential recovery, you or such other person consent to being so contacted and agree to cooperate in obtaining any recovery. Furthermore, you and any other person who may receive a potential recovery agree to segregate and hold any recovery in a separate fund for the purpose of reimbursing the plan the subrogated amount until such time as the subrogated amount has been reimbursed to the plan.

The plan may, in its sole discretion, require you or any other person, as a precondition of payment of benefits or advance of money, to sign a written assignment of any recovery to the plan to the extent of the subrogated amount. In the event that the plan does not receive payment of the subrogated amount, the plan and the plan administrator have the full discretion and authority, either together or individually, to bring any action against you or any other person who has received or may receive a recovery in any capacity or against any person responsible for the injuries or condition suffered or for the payment of any potential recovery, or reduce or set-off the subrogated amount against future benefit payments. Such action may include filing suit against you or such other person in a court of law to recover 100% of the subrogated amount plus the plan’s attorneys’ fees and court costs related to such suit.

Except as stated in the plan or as required by applicable law, the plan is not required to pay any expenses for past illnesses or injuries that are settled where you or another person have received a recovery, and the plan’s rights of subrogation and reimbursement of the subrogated amount apply even if the original injury or illness happened before coverage under the plan began.

The payment of benefits under the plan is conditioned upon the terms of this section and each person receiving benefits or advanced money from the plan agrees that such benefits or money is paid or advanced on condition of full reimbursement to the plan in the event of a recovery. By accepting any benefits under the plan, you are indicating your agreement to repay the subrogated amount. The plan’s rights to subrogation and reimbursement of the subrogated amount will not be reduced by any equitable defenses that may be raised by you or any third party (whether such third party has received benefits or is responsible for payment of a recovery), including, but not limited to, any common fund doctrine, contributory negligence doctrine, make whole doctrine or uninsured motorist rules or statutes. If any court of competent jurisdiction finds any portion of this section void or unenforceable, such portion shall be of no force and effect but shall not affect the validity or enforceability of any other portion hereof.

Claims and Appeals Process Under the Discover Benefit Plans

The following is a general summary of the claims and appeals process for Discover benefit plans.

In most cases, benefits to which you are entitled are paid upon your request. Depending on the program, in certain instances you request payment (sometimes referred to as a “claim” by the health program administrators) by sending a written claim form to the program’s administrator or insurer (such as Blue Cross Blue Shield and MetLife) or to myHR. Forms are available on the myHR website or from the claims administrator.

The appropriate administrator will either make the payments you request, advise Discover to make the payments or explain to you in writing why payment is denied. If you disagree with the explanation, you may file a claim. A “claim” is your first request for a review of the denial, and an “appeal” is your second request for review of the denial.

If my initial request for payment is denied, how do I file a claim for benefits?

If you have a question or concern, call myHR or the appropriate administrator’s member services as described in the Claims Administrators section before filing a claim. If myHR or member services cannot resolve the issue to your satisfaction, you or an authorized representative (your spouse or adult child, or a person authorized, in writing or by a court on your behalf) have the right to file a claim with the appropriate reviewer. Your claim must be in writing. Send all documentation that you consider relevant, and a statement of why you believe your claim should be granted, to the claim reviewer listed on the following page. If the Claims Committee or the Hearing Panel is the reviewer, send your claim to myHR. Otherwise, see the “Claims Administrators” section or contact myHR for the appropriate address. If you are not satisfied with the claim reviewer’s decision, you have the right to file an appeal (a second request for a review of your denial).

Who reviews my claim or appeal?

The person or entity that reviews your claim or appeal, called the “reviewer,” depends on the program involved, the type of request for review, the amount involved and whether it is a claim (your first level of review) or appeal (your second level of review). The following chart shows the reviewer for both claims and appeals.

If the amount involved is \$20,000 or less and the reviewer is the Discover Benefit Plan Claims Committee, your claim may instead be decided by Discover’s Director of Benefits (or his or her delegate). The Director of Benefits determines whether the amount involved exceeds \$20,000.

PROGRAM	TYPE OF REVIEW REQUESTED	CLAIM REVIEWER (FIRST LEVEL REVIEW)	APPEAL REVIEWER ¹ (SECOND LEVEL REVIEW)
BLUE CROSS BLUE SHIELD OPTIONS (INCLUDING PRESCRIPTION DRUG COVERAGE)	Type or amount of benefits payable	Claims Administrator (Blue Cross Blue Shield or Caremark)	Claims Administrator (Blue Cross Blue Shield or Caremark)
HMSA MEDICAL	Type or amount of benefits payable	Hawaii Medical Service Association	Hawaii Medical Service Association
SELECTHEALTH HMO	Type or amount of benefits payable	SelectHealth HMO	Select Med HMO
KAISER HMO	Type or amount of benefits payable	Kaiser HMO	Kaiser HMO
METLIFE DENTAL	Type or amount of benefits payable	MetLife	MetLife
VSP VISION	Type or amount of benefits payable	VSP	VSP
LIFE INSURANCE	Type or amount of benefits payable	Minnesota Life	Minnesota Life
SHORT-TERM DISABILITY (STD)	Type or amount of benefits payable	myHR	myHR

Continued on next page.

¹ Certain health plan administrators offer a voluntary third level of review. Check with your health plan administrator for details.

PROGRAM	TYPE OF REVIEW REQUESTED	CLAIM REVIEWER (FIRST LEVEL REVIEW)	APPEAL REVIEWER ¹ (SECOND LEVEL REVIEW)
LONG-TERM DISABILITY (LTD)	Type or amount of benefits payable	CIGNA	CIGNA
AD&D, BTA	Type or amount of benefits payable	LINA	LINA
FLEXIBLE SPENDING ACCOUNTS (FSAS)	Type or amount of benefits payable	ConnectYourCare	ConnectYourCare
LEGAL ASSISTANCE	Type or amount of benefits payable	Hyatt Legal Plans	Hyatt Legal Plans
MEDICAL, DENTAL, VISION, LIFE INSURANCE, STD, LTD, AD&D, BTA, LEGAL ASSISTANCE	Eligibility, coverage, amount of premiums and other matters not covered by administrator's or insurer's contract	Claims Committee	Hearing Panel
DISCOVER FINANCIAL SERVICES PENSION PLAN, 401(K) PLAN, EAP, SEVERANCE PAY PLAN	All	Claims Committee	Hearing Panel

When must I file a claim?

Your claim must be filed in a timely manner. Unless otherwise specified here, you must file your claim within 180 days following the date your initial request for benefits is denied.

If you want to file an appeal (the second level review) after your claim (the first level review) is denied, you must do so within 180 days following the denial of your claim. Certain insured programs (such as Kaiser HMO) require that appeals be made as soon as possible. Check with the insurer for details.

You may not bring a lawsuit to recover benefits under a benefit plan, enforce your rights under the terms of the plan or clarify your rights to future benefits under the plan, or challenge the plan administrator's (or claims administrator's or appeals administrator's) determinations until you have exhausted the plan's administrative process described in this SPD. If your appeal is denied, you have the right to file a lawsuit under ERISA, provided you do so before the earliest of:

- Six months following the date your appeal has been denied
- Three years following the date services related to the amount you are appealing were performed, or
- The end of the otherwise applicable statutory limitation period

If you fail to file by this period, any claim is barred. Except as otherwise preempted by federal law, the plan will be administered, construed and enforced according to the laws of the State of Illinois and in courts situated in Illinois.

When will I receive a decision on my claim or appeal?

Deadlines differ depending on the program involved, the nature of the review requested and whether it is a claim or appeal. Unless otherwise specified here, claims will be decided within 90 days of receipt, but a 90-day extension is allowed if the reviewer needs additional time due to special circumstances, and appeals will be decided within 60 days of receipt, but a 60-day extension is allowed if the reviewer needs additional time due to special circumstances.

¹ Certain health plan administrators offer a voluntary third level of review. Check with your health plan administrator for details.

DEFINITIONS

Urgent care review:

A claim that requires expedited notification or authorization for medical treatment because the longer time periods applicable to other types of reviews 1) could seriously jeopardize your life or health or ability to regain maximum function or 2) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the requested treatment. Urgent care reviews are decided on an expedited basis. Urgent care reviews may be requested orally, and all necessary information, including the decision on appeal, will be sent to you by telephone, fax or another expeditious method. If you do not provide sufficient information to determine whether, or to what extent, your claim is covered, you will be notified within 24 hours after the plan receives your claim of the specific information needed to complete the claim. You will have at least 48 hours to provide this information. If you do not follow the plan's procedures for filing an urgent care claim, you generally will be notified of the failure and the proper procedures within 24 hours.

Pre-service review:

A claim for treatment where prior plan approval or notification is required in order for the plan to cover the cost of the treatment or benefit. If you fail to submit needed information, the extension notice will describe the information needed and you will have 45 days to provide it. If you do not follow the plan's procedures for filing a pre-service claim, you generally will be notified within five days.

Concurrent care review:

May arise when the plan has approved treatment to be provided over a period of time or a number of treatments. A reduction or termination by the plan of the course of treatment (other than by plan amendment or termination) before the end of the originally approved period of time or number of treatments is considered a claim denial. If the plan has approved a course of treatment and subsequently reduces or terminates that approval, you will be given sufficient advance notice to allow you to appeal the decision before it takes effect. If a course of treatment involves urgent care, your claim will be decided as soon as possible, taking into account the medical exigencies, but within 24 hours after the plan receives your request, as long as your request is made at least 24 hours before the end of the course of treatment. If your request is not made at least 24 hours before the end of the course of treatment, it will be treated as a new urgent care claim and decided within the time frame described above for urgent care claims (within 72 hours). If a course of treatment does not involve urgent care, your request to extend the course of treatment will be treated as a new claim and decided within the time periods that apply to the type of claim (pre-service or post-service).

Post-service review:

A claim for which you do not need prior approval in order to have the benefit or treatment covered. A request for payment for medical care already received by you is a post-service claim. If a decision is not made within 30 days because you fail to submit necessary information, you will have 45 days to provide this information.

If your review is not for urgent care, pre-service or concurrent care, it will be treated as a post-service review. The following chart shows where different deadlines apply:

	CLAIM REVIEWER	APPEAL REVIEWER
MEDICAL, DENTAL AND VISION: URGENT CARE REVIEWS	ASAP, but within 72 hours of receipt; 48-hour extension after you provide any additional needed information	ASAP, but within 72 hours of receipt
MEDICAL, DENTAL AND VISION: PRE-SERVICE REVIEWS	15 days; 15-day extension	30 days
MEDICAL, DENTAL AND VISION: CONCURRENT CARE REVIEWS	See previous page	See next page
MEDICAL, DENTAL AND VISION: POST-SERVICE REVIEWS	30 days; 15-day extension	60 days
FSAS	30 days; 15-day extension	60 days
STD	45 days; 60-day extension	45 days; 45-day extension
LTD	45 days; 60-day extension	45 days; 45-day extension
LTC	60 days; 60-day extension	60 days; 60-day extension

What happens if my claim is denied?

If your claim is denied, in whole or in part, you will receive a written or electronic notice containing the following information (for urgent care medical review, you may receive oral notice followed by a written or electronic notice within three business days):

- The specific reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A description of any additional material or information which you must provide in order to complete your claim and an explanation of why such material or information is necessary; incomplete claims will be treated as part of the request for information and extension process and not as a denial unless you do not respond to the request for information within the required time period
- Instructions and deadlines for making an appeal, including a statement of your right to file a lawsuit under ERISA if your appeal is denied
- In the case of a health claim involving urgent care, a description of the expedited review process for these types of claims
- For health and disability programs, a statement that a free copy of any internal rule, guideline, protocol or other similar criterion relied on in denying your claim will be provided to you on request
- For health and disability programs, if the denial was based on a clinical judgment or experimental treatment or similar exclusion or limit, a statement that a free explanation will be provided to you upon request

How do I make an appeal if my claim is denied?

Your appeal must be in writing. Send a statement of why you believe your appeal should be granted, along with all documentation that you consider relevant, to the appeal reviewer listed above. You will be provided, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to your claim under applicable legal standards. If the Hearing Panel is the reviewer, send your documentation to myHR . If another person or entity is the reviewer, see the “Claims Administrators” section of this SPD or call myHR for the appropriate address.

Health and disability plans: The appeal reviewer will be someone other than the claim reviewer or its subordinate. The appeal reviewer will not give deference to the denial of claim. If your claim was denied based on a medical judgment, the appeal reviewer will consult with a health care professional who has appropriate training and experience in the relevant field of medicine (and who was not consulted in connection with the denial of your first claim). The appeal reviewer also will identify, at your request, any medical or vocational expert consulted in connection with the denial of your claim.

What happens if my appeal is denied?

If your appeal is denied, in whole or in part, you will receive a written or electronic notice containing the following information:

- The specific reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to your claim under applicable legal standards
- A statement of your right to file a lawsuit under ERISA after you have exhausted the plan's administrative claims and appeals procedures
- For health and disability programs, a statement that a free copy of any internal rule, guideline, protocol or other similar criterion relied on in denying your appeal will be provided to you on request
- For health and disability programs, if the denial was based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that a free explanation will be provided to you on request

May I have my appeal reheard?

You may be eligible to request an independent external review of a denied appeal related to medical benefits within four months after the date you receive notice that your appeal has been denied.

Within five business days after receipt of your external review request, the claims administrator will complete a preliminary review of the request to determine whether:

- The claimant was covered under the plan at the time the health care item or service was provided
- The denial of the appeal does not relate to a failure to meet eligibility requirements under the plan
- The claimant exhausted the plan's internal administrative claims and appeals processes, and
- The claimant provided all of the information and forms required to process an external review.

The claims administrator will notify you whether your appeal is eligible for external review or whether any additional information may be required, in which case you will have 48 hours to provide such additional information.

External reviews will be done by an Independent Review Organization ("IRO") that is not related to the claims administrator. Notice of the IRO's final decision will be made within 45 days of receipt of the appeal for review. Expedited IRO reviews may be available where delay would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function or if the final denied appeal relates to the availability of care, continued state or health care item or service for which the claimant received emergency services but has not been discharged from a facility. Notice of the IRO's decision will be made to the plan and to you and will contain:

- A general description of the reason for the review and all detail surrounding the claim such as date of service, health care provider, amount, etc.
- The date the IRO received the request for review and the date of IRO decision
- References to evidenced or documentation considered

- Discussion of the principal reasons for the IRO decision
- A statement that the decision is binding except as otherwise provided under applicable state or federal law
- A statement that judicial review may be available to the claimant
- Contact information for consumer health assistance

In addition to the required IRO review, certain health (medical, dental and vision) plan administrators offer a voluntary rehearing of your appeal by an independent third party called the “voluntary third level of review.” Not all health plan administrators offer the voluntary third level of review. Check with your health plan administrator.

The third level of review may be made only after your claim and appeal have both been denied. Your decision whether to submit an appeal to the voluntary third level of review will not affect any other rights you may have under the plan.

There is no charge for filing a voluntary third level of review.

You do not have to ask for a voluntary rehearing to bring a legal action for a benefit. The period of time in which your voluntary rehearing is processed will not be counted against you in determining the timeliness of any later legal action you may bring.

Contact your health plan administrator for more information about the voluntary third level of review.

All decisions of the appeal reviewer (or third level of review reviewer) are final, conclusive and binding. If, however, you believe that the reviewer did not follow the terms of the plan or has violated law, you may bring a legal action under ERISA. See the Your Rights—ERISA section in the Other Important Information section of this SPD. See “When must I file a claim?” for deadlines.

How do I contact the persons and entities named in these procedures?

Send all correspondence and documents to the Claims Committee, Hearing Panel, Director of Benefits or myHR to:

Discover myHR Service Center
Attn: Discover Benefit Determination Review Team
4 Overlook Point
P.O. Box 1407
Lincolnshire, IL 60069-1407
Fax: 847-554-1295

What else should I know about how the reviewers make decisions?

The administrators and fiduciaries of Discover’s benefit plans, including the reviewers, have discretionary authority to interpret the plans and make determinations under the plans. Any decision made pursuant to this authority is given full force and effect unless arbitrary or capricious. See the “Other Important Information” section of this SPD for details.

myHR Service Center Representatives

844-DFS-myHR **(844-337-6947)** (toll free)

8:00 am–6:00 pm, Central Time, Monday through Friday, except certain holidays

Website

resources.hewitt.com/discover

24 hours a day, seven days a week

Fax

847-554-1203

YOUR ERISA RIGHTS

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended, (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The plan administrator may make a reasonable charge for copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may be able to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description (see the section entitled "Continuation of Coverage Rights Under COBRA") and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduce or Eliminate Exclusionary Periods of Coverage for Pre-Existing Conditions Under Your Group Health Plan If You Have Creditable Coverage From Another Plan

You should be provided a certificate of creditable coverage, without charge, from your group health plan or health insurance issuer when you lose coverage under a group health plan, when you become entitled to elect COBRA continuation coverage; when your COBRA continuation coverage ceases; if you request it before losing coverage; or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Note: There are limitations on plans imposing a pre-existing condition exclusion and such exclusions are generally prohibited under the Affordable Care Act.

Prudent Action by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people, who operate the plan called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit to which you are entitled under the plan or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision, or lack thereof, concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that plan fiduciaries misuse the plan's money or you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

As described in the section, "Claims and Appeals Process" under the Discover Benefit Plans, you are required to exhaust the plan's administrative remedies before filing suit to recover benefits, enforce your rights under the plan or clarify your right to future benefits under the plan.

Assistance With Your Questions

If you have any questions about the plan, contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA.

CONTINUATION COVERAGE RIGHTS UNDER COBRA AND OTHER HEALTH COVERAGE ALTERNATIVES

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of any medical, dental, vision, and health care flexible spending account coverage you are enrolled in under the plan immediately prior to an event that causes you to lose eligibility for such coverage. This notice also contains important information about other health coverage options that may be available to you through the Health Insurance Marketplace at **HealthCare.gov** or **1-800-318-2596**. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. See the Health Insurance Marketplace section for additional details. Also, as noted in the "Live and Work Well Program" section, continuation of EAP coverage is available at no cost to you and your eligible family members through the COBRA period. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the plan and under federal law, contact myHR.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Group health plan coverage includes any medical, dental, vision and health care flexible spending account coverage you, your spouse, and your dependent children are enrolled in under the plan immediately prior to the qualifying event. Specific qualifying events are listed later in this notice. After a qualifying event occurs, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for that coverage.

You will become a qualified beneficiary if you lose your coverage under the plan because either one of the following qualifying events happens:

Your hours of employment are reduced; or

- Your employment ends for any reason other than your gross misconduct.

Your spouse will become a qualified beneficiary if he or she loses coverage under the plan because any of the following qualifying events happens:

- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- Your death;
- Your entitlement to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated.

Your dependent children will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happens:

- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- Your death;
- Your entitlement to Medicare benefits (under Part A, Part B, or both);
- Your divorce or legal separation; or
- The dependent stops being eligible for coverage under the plan as a “dependent child.”

When Is COBRA Coverage Available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after it has been notified that a qualifying event occurred. For the following qualifying events, Discover will notify myHR of the qualifying event:

- Your hours of employment are reduced
- Your employment ends
- Your death
- Your entitlement to Medicare benefits (under Part A, Part B, or both)

You Must Give Notice of Some Qualifying Events

For the following qualifying events, you or a family member must notify myHR within 60 days after the qualifying event occurs:

- Your divorce or legal separation; or
- Your dependent's loss of eligibility for coverage as a dependent child.

You must notify myHR of the qualifying event by accessing myHR at resources.hewitt.com/discover or calling 844-DFS-myHR (844-337-6947).

How Is COBRA Coverage Provided?

Once myHR receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect continuation coverage on behalf of your spouse and dependent children. Your spouse may also elect continuation coverage on behalf of your dependent children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is one of the following events, COBRA continuation coverage lasts for up to a total of 18 months for qualified beneficiaries:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

When the qualifying event is one of the following events, COBRA continuation coverage lasts for up to a total of 36 months for your spouse and dependent children:

- Your death;
- Your divorce or legal separation; or
- Your dependent stops being eligible for coverage under the plan as a "dependent child."

When the qualifying event is your reduction in hours or your termination of employment and you became entitled to Medicare benefits less than 18 months before the qualifying event, additional coverage for your spouse and dependents may be available. Your spouse and dependents would be eligible to receive up to 36 months of COBRA continuation coverage from the date of your entitlement to Medicare. For example, if you became entitled to Medicare 8 months before the date your employment terminates, COBRA continuation coverage for your spouse and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months prior to the qualifying event).

There are two other ways in which an 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of Continuation Coverage

COBRA coverage may be available for you and your family for up to a total of 29 months if all the following events occur:

- You, your covered spouse, or your covered dependents (including newborn and newly adopted children) are determined to be disabled as defined by the Social Security Act prior to the qualifying event or during the first 60 days of COBRA coverage;
- The Social Security Administration's disability determination is received within the disabled individual's 18 months of COBRA coverage;
- The disability must last at least until the end of the 18-month period of continuation coverage; and
- myHR is notified of the Social Security Administration's disability determination within 60 days of the disabled individual's receipt of a Social Security disability award. If the disability determination occurred before COBRA coverage started, you're required to notify myHR within the first 60 days of COBRA coverage.

You, your covered spouse, or your covered dependents must notify myHR within 60 days of receipt of the disability determination and prior to the end of the initial 18-month continuation period in order to receive the coverage extension. To notify myHR of the disability determination event, call 844-DFS-myHR **(844-337-6947)**.

You, your covered spouse, or your covered dependents must notify myHR within 30 days of the date the disability ends by calling 844-DFS-myHR **(844-337-6947)**.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. Additional continuation coverage is available only if the event would have caused your spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred. These events include:

- Your death;
- Your entitlement to Medicare (under Part A, Part B, or both);
- Your divorce or legal separation; or
- Your dependent stops being eligible for coverage under the plan as a “dependent child.”

You, your covered spouse, or your covered dependents must notify myHR within 60 days after the event occurs in order to receive this additional coverage. To notify myHR of the additional qualifying event, call 844-DFS-myHR **(844-337-6947)**.

Events That May Change Continued Coverage

Once your COBRA coverage begins, you may be able to change your COBRA coverage elections based on plan rules if you experience a qualified change in status. You, your covered spouse, or your covered dependents must notify myHR by calling 844-DFS-myHR **(844-337-6947)**, within 31 days of the qualified change in status to change your COBRA coverage.

See the “Qualified Life Events” section for detailed information on allowable changes in status. Adding family members to COBRA coverage may result in a higher premium for this additional coverage.

You may also change COBRA coverage if a child is born to the covered employee or placed for adoption with the covered employee during the 18-, 29-, or 36-month continuation period. In such cases, you must notify myHR by calling 844-DFS-myHR **(844-337-6947)**, within 31 days of the birth or placement to cover the new dependent as a qualified beneficiary under COBRA. There may be a higher premium for this additional coverage.

Events That End Continued Coverage

COBRA coverage will end automatically upon the expiration of the 18-, 29-, or 36-month continuation periods described on the previous pages. In addition, COBRA coverage will end automatically if any of the following situations occur:

- Discover stops providing group health benefits;
- Premiums are not paid within 30 days of the due date (with the exception of the initial premium which is due within 45 days of your election date); or
- A person eligible for continued benefits becomes covered under any other group health plan (unless the health plan has an enforceable preexisting condition clause) or becomes entitled to Medicare.

If your coverage ends because of expiration of the 18-, 29-, or 36-month limit, you may be able to convert coverage to an individual policy if this right currently exists in the plan.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with the COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to another coverage, you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

Health Insurance Marketplace

You are able to buy coverage through the Health Insurance Marketplace. In the marketplace, you could be eligible for a tax credit that lowers your monthly premiums. The marketplace allows you to see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage through the marketplace or to a tax credit. For more information about health insurance options available through a Health Insurance Marketplace, visit healthcare.gov or call **1-800-318-2596**.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though — if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- **Premiums:** Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- **Provider Networks:** If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- **Drug Formularies:** If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- **Severance payments:** If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at **1-866-444-3272** to discuss your options.
- **Service Areas:** Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

For more information

This notice doesn't fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact 844-DFS-myHR (**844-337-6947**).

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at **dol.gov/ebsa** or call their toll-free number at **1-866-444-3272**. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit **HealthCare.gov**.

Keep Your Plan Informed of Address Changes

To protect you and your family's rights, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

Your Rights Under ERISA

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Domestic Partner Coverage

COBRA does not provide continuation coverage for your domestic partner and his/her dependents. Discover offers coverage similar to COBRA coverage for domestic partners and their dependents. In general, the continuation of coverage offered for domestic partners is the same and subject to the same rules as the continuation coverage offered under COBRA.

For More Information

In the event of a qualifying event, you will receive information on your rights to continue coverage, including information on the cost of coverage. If you have any questions, you should visit myHR.

Web: resources.hewitt.com/discover

Phone: 844-DFS-myHR (844-337-6947), between 8 am and 6 pm Central Time, Monday through Friday

myHR is providing COBRA administration services on behalf of the plan administrator, Discover Financial Services. Please address any written correspondence to:

Discover myHR Service Center

P.O. Box 563906

Charlotte, NC 28256

YOUR RIGHTS TO HEALTH INSURANCE PORTABILITY UNDER HIPAA

If you terminate participation in the medical program, including terminating COBRA coverage, federal law may affect your medical coverage if you subsequently enroll or become eligible to enroll in medical coverage that excludes coverage for pre-existing medical conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be denied or excluded for medical conditions that you experienced or sought treatment for during the six months prior to the time you enroll in a group health plan (known as a "pre-existing condition"). Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). This means that you will receive treatment as provided under the new plan for conditions unrelated to your pre-existing condition, but benefits will be denied or excluded for your pre-existing condition until the end of the 12-month or 18-month waiting period. However, the 12-month (or 18-month) exclusion period is reduced by the length of time that you were covered under a prior health plan within the prior 63 days.

You are entitled to a certificate that will show evidence of the length of your prior medical coverage under this plan. If you buy medical insurance other than through an employer group medical plan, a certificate of prior coverage may also help you obtain credit against a pre-existing condition exclusion period. Contact your state insurance department for further information.

A certificate of prior coverage (referred to as “Certificate of Creditable Coverage”) will automatically be provided by myHR to you and to each of your dependents who were participating in the medical program at the time they ceased to participate in the plan. If you are beginning employment with a new employer, or purchasing individual coverage, check with your new plan administrator to see if your new plan excludes coverage for pre-existing conditions and if you need to provide a certificate or other documentation of your previous coverage. You can request a certificate by contacting myHR. The certificate will be provided to you promptly.

Your Privacy Rights: Notice of Privacy Practices

It is the plan’s policy to protect your medical information to the extent required by any applicable law, including HIPAA.

The plan may share your medical information with other Discover group health plans, with Discover and with others for the purposes of treatment, payment and health care operations and for certain other legally permitted purposes. To the extent required by law, Discover will not use any medical information about you to make employment-related decisions.

The plan will make reasonable efforts to use, share or request only the minimum necessary information to accomplish the intended purpose, taking into consideration practical and technological limitations. You also have certain privacy-related rights, including the right to access, request restrictions on and request amendments to your health records. Details about the plan’s privacy policies, including your privacy rights, are found in the Notice of Privacy Practices available on the Benefits Central website or by contacting myHR.

Patient Protection

The medical benefit programs generally allow for the designation of a primary care provider. You have the right to designate any primary care provider who participates in-network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in-network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approval treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, information on how to select a primary care provider and a list of participating primary care providers, contact myHR.

Medical Plan Coverage Resource

Summary of Benefit Coverage (SBC) documents are available to help you compare medical plans available to you. The SBCs illustrate key provisions of coverage under the medical plans and provide examples for you to reference. Current SBCs for each medical program can be found on www.mydiscoverbenefits.com and myHR at resources.hewitt.com/discover. For a free paper copy of SBCs, you may contact myHR at 844-DFS-myHR (844-337-6947).

Women’s Health and Cancer Rights Act of 1998

Do you know that your health program, as required by the Women’s Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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- All stages of reconstruction of the breast on which the mastectomy was performed;
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
 - Prostheses; and
 - Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance or copayment applicable to other medical and surgical benefits provided under the health program. Therefore, the same deductibles and coinsurance or copayment as in effect at the time of services apply. If you would like more information on WHCRA benefits, call myHR .

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Marketplace Notice

Discover is required to provide to all U.S. participants a Notice on Health Insurance Marketplace Coverage Options and Discover Benefits to comply with rules under the federal Patient Protection and Affordable Care Act (ACA), also known as Obamacare. The notice provides information on the health insurance marketplace coverage options and Discover benefits. For a free paper copy of the Marketplace Notice, call myHR at 844-DFS-myHR **(844-337-6947)**. If you need further information about the marketplace in your state, go to **healthcare.gov**, or call **800-318-2596**.

OTHER IMPORTANT INFORMATION

Plan Name and Numbers

Discover Financial Services Welfare Benefits Plan—501

Plan Year

The plan year runs from January 1 through December 31.

Administrative Information/Type of Administration

The plan is a welfare benefit plans subject to ERISA.

This SPD along with any insurance contracts constitutes the plan document. In addition to this SPD, there are other SPDs, which describe additional plan benefits, including severance pay and change in control severance.

The plan provides general welfare plan benefits to eligible employees and their eligible dependents. The welfare benefits described in this SPD include:

- Medical, dental and vision and prescription benefits
- Critical illness insurance
- Health care and dependent day care flexible spending account and health reimbursement account benefits
- Basic and supplemental life insurance

- Basic and supplemental AD&D insurance—provides accidental death and dismemberment insurance benefits
- BTA insurance—provides business travel accident benefits
- Disability insurance—provides short-term and long-term disability benefits
- Long-term care coverage—provides access to long-term care insurance for those eligible
- Legal assistance program—provides legal assistance benefits
- Employee assistance program—provides employee assistance benefits under the Live and Work Well Program
- Wellness benefits—provides annual health evaluation and wellness credit to eligible employees
- Commuter benefits—provides pre-tax commuter assistance benefits

Plan Sponsor

**Discover Financial Services,
c/o myHR Service Center
P.O. Box 563906
Charlotte, NC 28256**

844-DFS-myHR (844-337-6947) Federal Employer Identification Number: 36-2517428

In addition to the plan sponsor, the following companies are participating employers in the plan:

All majority-owned U.S. subsidiaries and affiliates of Discover Financial Services with U.S. employees are employers participating in the plan. As of January 1, 2015, the list of participating employers includes:

- Discover Financial Services
- Discover Bank
- Discover Products Inc.
- Pulse Network LLC
- DFS Services LLC
- DFS International Inc.
- Diners Club International, Ltd.
- Discover Financial Services Insurance Agency, Inc.
- The Student Loan Corporation Discover Home Loans, Inc. DFS Escrow, Inc. HLC Settlement Services, Inc.

An updated list of employers participating in the plan may be obtained by written request to the plan administrator at the address shown. Plan participants may also receive, upon written request to the plan administrator, information as to whether a particular employer participates in the plan, and if the employer does participate, the employer's address.

Plan Administrator and Named Fiduciary

**Discover Financial Services Employee Benefits Committee
c/o myHR Service Center
P.O. Box 563906
Charlotte, NC 28256
844-DFS-myHR (844-337-6947)**

Additionally, the plan administrator may delegate certain fiduciary functions to third-party administrators, including, without limitation, claims and appeals administration, as described in this SPD.

Agent for Service of Legal Process

The designated agent for the service of legal process is:

Law and Compliance Department

Attn: General Counsel

Discover Financial Services

2500 Lake Cook Road

Riverwoods, IL 60015

Service of legal process also may be made on the plan administrator.

Plan Funding

Certain medical benefits under the Discover Welfare Benefit Program are self-funded. Discover pays administrative fees to Blue Cross Blue Shield and CVS Caremark and funds benefit payments from general assets and employee contributions, as determined by Discover in its discretion. These benefits are not insured by Discover, Blue Cross Blue Shield or Caremark. Certain benefits under the Discover Health and Welfare Benefits Program are insured through insurance contracts. Discover pays insurance premiums to Hawaii Medical Services Association, SelectHealth and Kaiser from general assets and employee contributions, as determined by Discover in its discretion.

Benefits under the MetLife dental program are fully insured. Discover pays insurance premium to Metropolitan Life Insurance Company ("MetLife") for the MetLife dental program and funds from general assets and employee contributions.

Benefits under the vision program are funded by a fully insured policy with Eastern Vision Service Plan, Inc. (VSP). Discover pays insurance premium to VSP from employee contributions.

The basic and voluntary critical illness insurance program premiums are paid from general assets and employee contributions. MetLife is responsible for paying your benefits only as provided under the terms of the insurance policy.

The FSA program is an unfunded plan. All payments are made from Discover's general assets. This means that your "contributions" described in this SPD are actually your salary reductions, credited to your bookkeeping accounts under the FSA. Your HCFSAs are credited with the full amount of your election at the beginning of the year and you may make a claim from your HCFSAs whether or not your salary has been reduced by the amount of your claim. Your DDCFSAs are credited with the amount of your salary reductions as they are made, and you may make a claim from your DDCFSAs to the extent your account has a positive balance. As of December 31, any amount not claimed by you for DDCFSAs eligible expenses (and above \$500 for HCFSAs eligible expenses) is forfeited from your bookkeeping accounts. Benefits under the FSA are not insured by ConnectYourCare in the unlikely event that Discover is unable to pay claims under the FSA.

Your HSA is opened the first of the month after coverage takes effect. Your HSA is funded through your "contributions" or salary reductions as described in this SPD. Your HSA is credited with your contributions on a pay period basis during the plan year. Discover contributions to your HSA are provided quarterly beginning January 1. Other contributions will be made after the end of the calendar quarter, as soon as administratively possible. You will have access to the entire annual amount by October. For new hires, your first quarterly Discover contribution will be made at the end of the quarter after the effective date of your coverage.

Your HRA is funded with Discover contributions beginning January 1. For new hires, the HRA is prorated and funded based on the quarter in which you are hired.

The basic and supplemental life insurance program is funded through one or more fully insured policies issued by Minnesota Life. Premiums are paid from general assets and employee contributions. Minnesota Life is responsible for paying your benefits only as provided under the terms of the insurance policy. In the event the policy terminates, Minnesota Life will no longer be responsible for benefit payments other than as provided upon termination of the policy.

Basic and supplemental AD&D insurance program and BTA insurance program benefits are funded through one or more fully insured policies issued by LINA. Premiums are paid from general assets and employee contributions. LINA is responsible for paying benefits only as provided under the terms of the insurance policies. In the event that either policy terminates, LINA will no longer be responsible for benefit payments other than as provided upon the termination of the policy.

STD benefits are self-funded through the general assets of Discover. LTD is funded through a group insurance policy with CIGNA and premiums paid from employee contributions.

Discover pays premiums for benefits under the legal assistance program to Hyatt Legal Plans from employee contributions. Hyatt Legal is the claims administrator and assumes responsibility to pay all benefits under the Program.

Employee assistance and wellness programs are self-funded through the general assets of Discover.

Discover pays for commuter benefits from employee contributions and through the general assets of Discover.

Discover pays administrative fees from general assets to AonHewitt for benefits recordkeeping and administration and for the administration of COBRA.

Claim Administrators

Medical Plans

- Blue Cross Blue Shield of Illinois, 300 East Randolph, Chicago IL 60601
- CVS Caremark, 2211 Sanders Road, Northbrook IL 60062
- Hawaii Medical Service Association, P.O. Box 860, Honolulu HI 96814
- SelectHealth, 4646 West Lake Park Boulevard, Salt Lake City UT 84120
- Kaiser HMO, California Service Center, P.O. Box 23448, San Diego CA 92193-3488

Critical Illness Program

MetLife, Critical Illness Insurance Service Center, P.O. Box 6120, Scranton PA 18505-9972

Flexible Spending Accounts Program

ConnectYourCare, 307 International Circle, Suite 200, Hunt Valley MD 21030 / Phone: **410-891-1000**

Dental Program

MetLife, P.O. Box 981282, El Paso TX 79998-1282

Vision Program

VSP, 3333 Quality Drive Rancho, Cordova CA 95670 / Phone: **800-877-7195**

Basic and Supplemental Life Insurance Program

Minnesota Life, 400 Robert Street North, St. Paul MN 55101-2098 / Phone: **888-658-0193**

Basic and Supplemental AD&D Insurance Program and BTA

Life Insurance Company of North America, 1600 West Carson Street, Suite 300, Pittsburgh PA 15219

Short-Term Disability Program

Discover Leave Administration, P.O. Box 1548, Farmington CT 06034 / Phone: 844-DFS-myHR (**844-337-6947**)

Fax: **847-554-1650**

Long-Term Disability Program

CIGNA, 1640 Dallas Parkway, Plano TX 75093 / Phone: **800-352-0611**

Legal Assistance Program

Hyatt Legal Plans, Inc., 1111 Superior Avenue, Cleveland OH 44114-2507 / Phone: **800-821-6400**

Commuter Benefits Program

WageWorks, P.O. Box 14053, Lexington KY 40512 / Phone: **877-353-9236**

If the Plan Is Terminated or Modified

Although Discover and its affiliates expect to continue the plan and each of the programs indefinitely, Discover Financial Services, by action of its Board of Directors (or its delegate, the Senior Vice President—Human Resources), necessarily reserves the right to amend, modify or discontinue the plan or any benefits under any of the programs offered the plan at any time for any reason or from time to time.

Plan Documents Govern

To the extent benefits are provided under an insurance contract, benefits provided by the plan are limited to the coverage of the insurance contract. No provision in the plan document or SPD is intended to conflict with any provision of any such insurance contract.

No Guarantee of Employment

Neither this SPD nor participation in the plan is a guarantee of continued employment.

Confirmation of Your Elections

Any elections that you make under the plan will become effective once the election is processed by myHR (and EOI is approved, if applicable) and you are actively at work (for LTD and life Insurance). You will receive confirmation of your elections (either electronic or paper), which you should check carefully to make sure that it reflects your intent. If it is incorrect, call a benefits representative immediately. If you do not receive a confirmation online or in the mail within 10 business days, it is your responsibility to call a benefits representative.

It is your responsibility to follow up on any election that requires EOI.

Right to Audit

Discover audits the coverage of dependents, including spouses, domestic partners and children, to ensure that no ineligible person is enrolled in the plan. Any person who fails to cooperate or who intentionally provides false or misleading information to the plan for the purpose of obtaining benefits may lose any or all benefit coverage and will be required to repay any benefits improperly received. Employees may be subject to further corrective action, up to and including termination of employment and forfeiture of executive compensation.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the plan, the plan administrator and other plan fiduciaries shall have the exclusive right and discretionary authority to make any findings necessary or appropriate for any purpose under the plan, including to interpret the terms of the plan and to determine eligibility for and entitlement to plan benefits. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Indemnification

To the fullest extent permitted by law, Discover and its affiliates will indemnify and hold harmless the plan administrator, each member of the Employee Benefits Committee, the Claims Committee, the Hearing Panel and each other employee, officer and director of Discover or of any member of Discover's Affiliated Group, to whom fiduciary responsibilities are delegated under the plan against any cost or expense (including attorneys' fees) or liability (including any sum paid in settlement of a claim with the approval of Discover) arising out of any act or omission to act, except in the case of willful misconduct or lack of good faith.

Plan Expenses

All fees and expenses incurred in connection with the operation and administration of the plan, including legal, accounting, actuarial, investment, Trustee, management and administrative fees and expenses may be paid out of any trust or plan assets to the extent legally permitted. The plan sponsor may advance amounts properly payable by the plan or trust and then obtain reimbursement from the plan or trust.

Governing Law

The plan shall be governed by federal law, and, to the extent not preempted by federal law, including but not limited to the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Patient Protection and Affordable Care Act, and the laws of the State of Illinois.

GLOSSARY

ADMINISTRATOR PROGRAM

means programs for which a hospital has a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide service to you at the time services are rendered to you. These programs are limited to a partial hospitalization treatment program or coordinated home care program.

AMBULANCE TRANSPORTATION

means local transportation in a specially equipped certified vehicle from your home, scene of accident or medical emergency to a hospital, between hospital and hospital, between hospital and skilled nursing facility or from a skilled nursing facility or hospital to your home. If there are no facilities in the local area equipped to provide the care needed, ambulance transportation then means the transportation to the closest facility that can provide the necessary service.

AMBULATORY SURGICAL FACILITY

means a facility (other than a hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

An “**ADMINISTRATOR AMBULATORY SURGICAL FACILITY**” means an ambulatory surgical facility that has a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to you at the time services are rendered to you.

A “**NON-ADMINISTRATOR AMBULATORY SURGICAL FACILITY**” means an ambulatory surgical facility that does not meet the definition of an administrator ambulatory surgical facility.

ANESTHESIA SERVICES

means the administration of anesthesia and the performance of related procedures by a physician or a certified registered nurse anesthetist that may be legally rendered by them respectively.

CALENDAR YEAR

means a period of one year beginning January 1.

CERTIFICATE OF CREDITABLE COVERAGE

means a certificate disclosing information relating to your creditable coverage under a health care benefit program for purposes of reducing any pre-existing condition exclusion imposed by any group health plan coverage.

CERTIFIED CLINICAL NURSE SPECIALIST

means a nurse specialist who

- (a) is licensed under the nursing and advanced practice nursing act;
- (b) has an arrangement or agreement with a physician for obtaining medical consultation, collaboration and hospital referral and
- (c) meets the following qualifications:
 - i. Is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
 - ii. Is a graduate of an advanced-practice nursing program.

A “**PARTICIPATING CERTIFIED CLINICAL NURSE SPECIALIST**” means a certified clinical nurse specialist who has a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to you at the time services are rendered.

A “**NON-PARTICIPATING CERTIFIED CLINICAL NURSE SPECIALIST**” means a certified clinical nurse specialist who does not have a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to you at the time services are rendered.

CERTIFIED NURSE-MIDWIFE

means a nurse-midwife who

- (a) practices according to the standards of the American College of Nurse-Midwives;
- (b) has an arrangement or agreement with a physician for obtaining medical consultation, collaboration and hospital referral and
- (c) meets the following qualifications:
 - i. Is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
 - ii. Is a graduate of a program of nurse-midwives accredited by the American College of Nurse-Midwives or its predecessor.

A **“PARTICIPATING CERTIFIED NURSE-MIDWIFE”** means a certified nurse-midwife who has a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to you at the time services are rendered.

A **“NON-PARTICIPATING CERTIFIED NURSE-MIDWIFE”** means a certified nurse- midwife who does not have a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to you at the time services are rendered.

CERTIFIED NURSE PRACTITIONER

means a nurse practitioner who

- (a) is licensed under the Nursing and Advanced Practice Nursing Act;
- (b) has an arrangement or agreement with a physician for obtaining medical consultation, collaboration and hospital referral and
- (c) meets the following qualifications:
 - i. Is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
 - ii. Is a graduate of an advanced-practice nursing program.

A **“PARTICIPATING CERTIFIED NURSE PRACTITIONER”** means a certified nurse practitioner who has a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to you at the time services are rendered.

A **“NON-PARTICIPATING CERTIFIED NURSE PRACTITIONER”** means a certified nurse practitioner who does not have a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to you at the time services are rendered.

CERTIFIED REGISTERED NURSE ANESTHETIST or CRNA

means a nurse anesthetist who:

- (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse;
- (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors;
- (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and
- (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

A **“PARTICIPATING CERTIFIED REGISTERED NURSE ANESTHETIST”** means a certified registered nurse anesthetist who has a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to you at the time services are rendered.

A **“NON-PARTICIPATING CERTIFIED REGISTERED NURSE ANESTHETIST”** means a certified registered nurse anesthetist who does not have a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to you at the time services are rendered.

CLAIM

means notification in a form acceptable to the claim administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which the claim administrator may request in connection with services rendered to you.

CLAIM ADMINISTRATOR

means Blue Cross Blue Shield of Illinois.

CLAIM CHARGE

means the amount that appears on a claim as the provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the claim administrator and a particular provider.

CLAIM PAYMENT

means the benefit payment calculated by the claim administrator, after submission of a claim, in accordance with the benefits described in this benefit booklet. All claim payments will be calculated on the basis of the eligible charge for covered services rendered to you, regardless of any separate financial arrangement between the claim administrator and a particular provider.

CLINICAL LABORATORY

means a clinical laboratory that complies with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, the Medicare and Medicaid programs and any applicable state and local statutes and regulations.

A **"PARTICIPATING CLINICAL LABORATORY"** means a clinical laboratory that has a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to you at the time services are rendered.

A **"NON-PARTICIPATING CLINICAL LABORATORY"** means a clinical laboratory that does not have a written agreement with the claim administrator or another Blue Cross Blue Shield plan provide services to you at the time services are rendered.

CLINICAL PROFESSIONAL COUNSELOR

means a duly licensed clinical professional counselor.

A **"PARTICIPATING CLINICAL PROFESSIONAL COUNSELOR"** means a clinical professional counselor who has a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to you at the time services are rendered.

A **"NON-PARTICIPATING CLINICAL PROFESSIONAL COUNSELOR"** means a clinical professional counselor who does not have a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to you at the time services are rendered.

CLINICAL SOCIAL WORKER

means a duly licensed clinical social worker.

A **"PARTICIPATING CLINICAL SOCIAL WORKER"** means a clinical social worker who has a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to you at the time services are rendered.

A **"NON-PARTICIPATING CLINICAL SOCIAL WORKER"** means a clinical social worker who does not have a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to you at the time services are rendered.

COINSURANCE

means a percentage of an eligible expense that you are required to pay towards a covered service.

CONGENITAL OR GENETIC DISORDER

means a disorder that includes, but is not limited to, hereditary disorders. Congenital or genetic disorders may also include, but is not limited to, autism or an autism spectrum disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma or injury.

COORDINATED HOME CARE PROGRAM

means an organized skilled patient care program in which care is provided in the home. Care may be provided by a hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require skilled nursing service on an intermittent basis under the direction of your physician. This program includes skilled nursing service by a registered professional nurse, the services of physical, occupational and speech therapists, hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for private duty nursing service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

An **"ADMINISTRATOR COORDINATED HOME CARE PROGRAM"** means a coordinated home care program that has a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide service to you at the time service is rendered to you.

A **"NON-ADMINISTRATOR COORDINATED HOME CARE PROGRAM"** means a coordinated home care program that does not have an agreement with the claim administrator or a Blue Cross Blue Shield plan but has been certified as a home health agency in accordance with the guidelines established by Medicare.

COPAYMENT OR COPAY

means a specified dollar amount that you are required to pay towards a covered service.

COVERED SERVICE

means a service and supply for which benefits will be provided.

CUSTODIAL CARE SERVICE

means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial care services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.). Custodial care service also means providing care on a continuous inpatient or outpatient basis without any clinical improvement by you.

DEDUCTIBLE

each benefit period, you must satisfy a deductible for covered services rendered by participating provider(s) and a separate deductible for covered services rendered by non-participating provider(s) or non-administrator provider(s). In other words, after you have claims for covered services for more than the deductible amount in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.

If you have family coverage and your family has reached the program deductible amount for covered services rendered by participating provider(s) and a separate program deductible for covered services rendered by non-participating provider(s) or non-administrator provider(s), it will not be necessary for anyone else in your family to meet the program deductible in that benefit period. That is, for the remainder of that benefit period only, no other family member(s) is required to meet the program deductible before receiving benefits. A family member may not apply more than the individual program deductible amount toward the family program deductible.

DIAGNOSTIC SERVICE

means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, X-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

DIALYSIS FACILITY

means a facility (other than a hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

An “**ADMINISTRATOR DIALYSIS FACILITY**” means a dialysis facility that has a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to you at the time services are rendered to you.

A “**NON-ADMINISTRATOR DIALYSIS FACILITY**” means a dialysis facility that does not have an agreement with the claim administrator or another Blue Cross Blue Shield plan but has been certified in accordance with the guidelines established by Medicare.

ELIGIBLE CHARGE

means

- (a) in the case of a provider, other than a professional provider, which has a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide care to you at the time covered services are rendered, such provider’s claim charge for covered services and
- (b) in the case of a provider, other than a professional provider, which does not have a written agreement with the claim administrator or another BlueCross and/or Blue Shield plan to provide care to you at the time covered services are rendered, will be the lesser of:
 - i. The provider’s billed charges, or

- ii. The claim administrator non-contracting eligible charge. Except as otherwise provided in this section, the non-contracting eligible charge is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

Notwithstanding the preceding sentence, the non-contracting eligible charge for coordinated home care program covered services will be 50% of the non-participating or non-administrator provider’s standard billed charge for such covered services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the claim.

When a Medicare reimbursement rate is not available for a covered service or is unable to be determined on the information submitted on the claim, the eligible charge for non-participating or non-administrator providers will be 50% of the non-participating or non-administrator provider’s standard billed charge for such covered service.

The claim administrator will utilize the same claim processing rules and/or edits that it utilizes in processing participating provider claims for processing claims submitted by non-participating or non-administrator providers which may also alter the eligible charge for a particular service. In the event the claim administrator does not have any claim edits or rules, the claim administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The eligible charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the claim administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services or its successor.

EMERGENCY MEDICAL CARE

means services provided for the initial outpatient treatment, including related diagnostic services, of a medical condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in:

- i. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- ii. Serious impairment to bodily functions; or
- iii. Serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

HOSPICE CARE PROGRAM SERVICE

means a centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice care program service is available in the home, skilled nursing facility or special hospice care unit.

HOSPITAL

means a duly licensed institution for the care of the sick that provides service under the care of a physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, or custodial homes of the aged or similar institutions.

An “**ADMINISTRATOR HOSPITAL**” means a hospital that has a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to you at the time services are rendered to you.

A “**NON-ADMINISTRATOR HOSPITAL**” means a hospital that does not meet the definition of an administrator hospital.

A “**PARTICIPATING HOSPITAL**” means an administrator hospital that has an agreement with the claim administrator or another Blue Cross Blue Shield plan to provide hospital services to participants in the participating provider option program.

A “**NON-PARTICIPATING HOSPITAL**” means an administrator hospital that does not meet the definition of a participating hospital.

INPATIENT

means that you are a registered bed patient and are treated as such in a health care facility.

INVESTIGATIONAL OR INVESTIGATIONAL SERVICES AND SUPPLIES

means procedures, drugs, devices, services and/or supplies which

1. are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or
2. are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and
3. specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

MAXIMUM ALLOWANCE

means the amount which participating professional providers have agreed to accept as payment in full for a particular covered service. All benefit payments for covered services rendered by participating professional providers will be based on the schedule of maximum allowances that these providers have agreed to accept as payment in full. For non-participating professional providers, the maximum allowance will be the lesser of:

- i. The provider's billed charges, or
- ii. The claim administrator non-contracting maximum allowance. Except as otherwise provided in this section, the non-contracting maximum allowance is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

Notwithstanding the preceding sentence, the non-contracting maximum allowance for coordinated home care program covered services will be 50% of the non-participating professional provider's standard billed charge for such covered services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the claim.

When a Medicare reimbursement rate is not available for a covered service, or is unable to be determined on the information submitted on the claim, the maximum allowance for non-participating professional providers will be 50% of the non-participating professional provider's standard billed charge for such covered service.

The claim administrator will utilize the same claim processing rules and/or edits that it utilizes in processing participating professional provider claims for processing claims submitted by non-participating professional providers, which may also alter the maximum allowance for a particular service. In the event the claim administrator does not have any claim edits or rules, the claim administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The maximum allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the claim administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

MEDICARE

means the program established by Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

MENTAL ILLNESS

means those illnesses classified as disorders in the current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

OCCUPATIONAL THERAPY

means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational therapy does not include educational training or services designed and adapted to develop a physical function.

PHYSICAL THERAPY

means the treatment of a disease, injury or condition by physical means by a physician or a registered professional physical therapist under the supervision of a physician and which is designed and adapted to promote the restoration of a useful physical function. Physical therapy does not include educational training or services designed and adapted to develop a physical function.

PHYSICIAN

means a physician, duly licensed to practice medicine in all of its branches.

PHYSICIAN ASSISTANT

means a duly licensed physician assistant performing under the direct supervision of a physician, dentist or podiatrist and billing under such provider.

PRIVATE DUTY NURSING SERVICE

means skilled nursing service provided on a one-to-one basis by an actively practicing Registered Nurse (R.N.), or Licensed Practical Nurse (L.P.N.). Private duty nursing is shift nursing of 8 hours or greater, per day, and does not include nursing care of less than 8 hours per day. Private duty nursing service does not include custodial care service.

PROVIDER

means any health care facility (for example, a hospital or skilled nursing facility) or person (for example, a physician or dentist) or entity duly licensed to render covered services to you.

An **“ADMINISTRATOR PROVIDER”** means a provider who has a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to you at the time services are rendered to you.

A **“NON-ADMINISTRATOR PROVIDER”** means a provider that does not meet the definition of administrator provider unless otherwise specified in the definition of a particular provider.

A **“PARTICIPATING PROVIDER”** means an administrator hospital or professional provider which has a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to participants in the participating provider option program or an administrator facility which has been designated by the claim administrator as a participating provider.

A **“NON-PARTICIPATING PROVIDER”** means an administrator hospital or professional provider which does not have a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to participants in the participating provider option program or a facility

which has not been designated by the claim administrator as a participating provider.

A **“PROFESSIONAL PROVIDER”** means a physician, dentist, podiatrist, psychologist, chiropractor, optometrist or any provider designated by the claim administrator or another Blue Cross Blue Shield plan.

A **“PARTICIPATING PRESCRIPTION DRUG PROVIDER”** means a pharmacy that has a written agreement with the claim administrator or the entity chosen by the claim administrator to administer its prescription drug program to provide services to you at the time you receive the services.

RESIDENTIAL TREATMENT CENTER

means a facility setting offering therapeutic intervention and special programming in a controlled environment that also offers a degree of security, supervision and structure. Patients are medically monitored with 24-hour medical availability and 24-hour onsite nursing service for patients with mental illness and/or substance abuse disorders.

SKILLED NURSING FACILITY

means an institution or a distinct part of an institution that is primarily engaged in providing comprehensive skilled services and rehabilitative inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

An **“ADMINISTRATOR SKILLED NURSING FACILITY”** means a skilled nursing facility that has a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to you at the time services are rendered to you.

A **“NON-ADMINISTRATOR SKILLED NURSING FACILITY”** means a skilled nursing facility that does not have an agreement with the claim administrator or another Blue Cross Blue Shield plan but has been certified in accordance with guidelines established by Medicare.

An **“UNCERTIFIED SKILLED NURSING FACILITY”** means a skilled nursing facility that does not meet the definition of an administrator skilled nursing facility and has not been certified in accordance with the guidelines established by Medicare.

SPEECH THERAPY

means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech therapy does not include educational training or services designed and adapted to develop a physical function.

SUBSTANCE ABUSE

means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency that develops with continued use of such addictive substances requiring medical care as determined by a behavioral health practitioner.

SUBSTANCE ABUSE REHABILITATION TREATMENT

means an organized, intensive, structured, rehabilitative treatment program of either a hospital or substance abuse treatment facility. It does not include programs consisting primarily of counseling by individuals other than a behavioral health practitioner, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

SUBSTANCE ABUSE TREATMENT FACILITY

means a facility (other than a hospital) whose primary function is the treatment of substance abuse and is licensed by the appropriate state and local authority to provide such service. It does not include halfway houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

An “**ADMINISTRATOR SUBSTANCE ABUSE TREATMENT FACILITY**” means a substance abuse treatment facility that has a written agreement with the claim administrator or another Blue Cross Blue Shield plan to provide services to you at the time services are rendered to you.

A “**NON-ADMINISTRATOR SUBSTANCE ABUSE TREATMENT FACILITY**” means a substance abuse treatment facility that does not meet the definition of an administrator substance abuse treatment facility.

SURGERY

means the performance of any medically recognized, non-investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the claim administrator.

BENEFIT PROVIDER CONTACTS				
PLAN	ADMINISTRATOR	GROUP NUMBER	WEBSITE	PHONE
All Plans	myHR	N/A	To learn about enrollment: www.mydiscoverbenefits.com To enroll and manage benefits: resources. hewitt.com/discover	844-DFS-myHR (844-337-6947)
MEDICAL				
Blue Cross Blue Shield (BCBS) Medical Plans, including: <ul style="list-style-type: none">• 24/7 NurseLine• Health coaching• Decision support• Disease management	BCBS of Illinois	PPO: 256916 HRA: 256917 HSA: 256922	bcbsil.com	877-217-7985
Critical Illness Insurance	MetLife	N/A	metlife.com/mybenefits	800-GET-MET8 (800-438-6388)
SelectHealth (Select Med HMO and HSA)	SelectHealth	G1007059	selecthealth.org	800-538-5038
HMSA Medical Plan (for residents of Hawaii only)	Hawaii Medical Service Association	11487-1-7	hmsa.com	808-948-6111
Kaiser HMO	Kaiser Permanente	231121	kp.org	800-443-0815
ConnectYourCare (HSA and FSA administrator)	ConnectYourCare	N/A	connectyourcare.com	888-285-9499
HSA Bank	HSA Bank Account	N/A	hsabank.com/ hsabank/members	800-357-6246
PRESCRIPTION DRUGS				
BCBS Medical Plans	CVS Caremark	DCSRX	caremark.com	888-739-7987
WORK/LIFE MANAGEMENT				
Live and Work Well Program	Optum/United Behavioral Health	N/A	liveandworkwell.com (access code: Discover)	800-622-7276
Health Evaluation	Interactive Health	N/A	myinteractivehealth.com	800-840-6100
QuitPower	Optum/United Behavioral Health	N/A	liveandworkwell.com (access code: Discover)	877-784-8797

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BENEFIT PROVIDER CONTACTS				
PLAN	ADMINISTRATOR	GROUP NUMBER	WEBSITE	PHONE
DENTAL				
MetLife Dental Plan—Standard and Premier Options	MetLife	139358	metlife.com/mybenefits	Member Services: 800-942-0854 Directories: 800-474-7371
VISION				
VSP Vision Plan—Standard and Premier Options	VSP	12309573	vsp.com	800-877-7195
FLEXIBLE SPENDING ACCOUNTS (FSAS)				
Health Care and Dependent Day Care	ConnectYourCare	N/A	connectyourcare.com	888-285-9499
LIFE INSURANCE				
Basic and Supplemental	Minnesota Life	33953-G	lifebenefits.com	866-293-6047
ACCIDENT INSURANCE				
Basic and Supplemental AD&D	LINA	OK980085	N/A	N/A
Business Travel Accident	LINA	ABL980064	N/A	N/A
DISABILITY INSURANCE				
Short-Term	myHR	N/A	resources.hewitt.com/discover	844-DFS-myHR (844-337-6947)
Long-Term	CIGNA	VDT980047	N/A	800-352-0611

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BENEFIT PROVIDER CONTACTS				
PLAN	ADMINISTRATOR	GROUP NUMBER	WEBSITE	PHONE
OTHER IMPORTANT CONTACTS				
Adoption Assistance Program	Discover	N/A	E-mail: sharedservices@discover.com	N/A
COBRA	myHR	N/A	resources.hewitt.com/discover	844-DFS-myHR (844-337-6947)
Commuter Benefits Program	WageWorks	N/A	wageworks.com	877-WAGEWORKS (877-924-3967)
Employee Stock Purchase Plan (ESPP)	Computershare	N/A	resources.hewitt.com/discover	877-272-7531
Group Auto, Home and Pet Insurance Program	MetLife	N/A	metlife.com/mybenefits	800-GET-MET8 (800-438-6388)
Legal Assistance Plan	Hyatt Legal Plans	N/A	metlife.com/mybenefits	800-GET-MET8 (800-438-6388)
Pet Insurance	MetLife	N/A	metlife.com/mybenefits	800-GET-MET8 (800-438-6388)
Medicare		N/A	medicare.gov	800-633-4227
Social Security Administration		N/A	socialsecurity.gov	800-772-1213

Claim Forms

Claim forms are available on myHR at **resources.hewitt.com/discover** or from the contacts above.

ABOUT THIS BOOKLET

This booklet is the Summary Plan Description (SPD) for the medical, dental, vision, critical illness, prescription drug, flexible spending accounts, life and accident, disability, long-term care, commuter benefits, legal and employee assistance and pre-tax benefits offered under the Discover Financial Services Welfare Benefits Plan (“plan”) as in effect January 1, 2015. This SPD explains in easy-to-understand language the applicable terms of the plan. Additional SPDs and booklets are available for other benefits offered under the plan, including severance pay and change in control severance benefits. You should read this SPD carefully and keep it with your other important papers for future reference.

Discover Financial Services (“Discover”) sponsors the plan and reserves the right to amend the plan or discontinue the plan at any time in its sole discretion.

We hope you find this information helpful to you and your family. If you have questions, you should contact myHR:

- Online: **resources.hewitt.com/discover**
Online service is generally available 24 hours a day, 7 days a week
- By phone: 844-DFS-myHR (**844-337-6947**)
You may contact a myHR Service Center Representative by phone from 8 am to 6 pm Central Time, Monday through Friday, except certain holidays.

There is a great deal of plan information available to you through **www.mydiscoverbenefits.com**, and myHR. Once you become eligible to participate in the plan, visit the myHR website or call a representative to enroll, name a beneficiary and make or change benefit elections. After you have begun participating, refer back regularly to myHR and **www.mydiscoverbenefits.com**, for updated information, including annual enrollment materials and other summaries of material modification and other important notices regarding the plan and administration. If you do not have access to the Internet, you may obtain access to all of this information by calling a representative.

The plan provides eligible employees of Discover and its participating affiliates and, in certain cases, their eligible dependents with welfare benefits under several different programs offered from time to time (“programs”). This SPD summarizes some of the benefits provided under the plan, as noted above. Other benefits provided under the plan are summarized in other SPDs. This booklet and certain other documents, including such other SPDs, any applicable insurance contracts, and any other applicable plan documents incorporated in to and are a part of the official plan documents. If there is any conflict between the information in the plan documents and any other materials, including any verbal representation, the plan documents control.

